GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

BLUE COMPREHENSIVE
BENEFIT BOOKLET

Effective: January 1, 2023

This benefit booklet ("Booklet") describes the benefits offered under the Blue Comprehensive option of the Greater Tompkins County Municipal Health Insurance Consortium ("GTCMHIC" or "Plan"). In addition to the Blue Comprehensive option described in this Booklet, the Plan offers the following other coverage options: Blue Secure, Blue Traditional Options (1, 2 & 3), Metal Level Options (Bronze, Silver, Gold and Platinum) and PPO Options (1, 2, 3, & 4). These other coverage options are described in separate booklets.

The Plan is considered a municipal cooperative health benefit plan. The Plan is not a licensed insurer. It operates under a more limited Certificate of Authority granted by the New York State Superintendent of Financial Services. Municipal corporations participating in the Plan are subject to contingent assessment liability.

Benefits described in this Booklet are offered to eligible employees (and eligible Dependents) of participating counties and municipalities ("Participating Employers"), on the terms and conditions set forth herein. Not all Participating Employers that participate in the Plan offer all coverage options. Your employer will provide You with information regarding what coverage options are available to You. You may also contact the GTCMHIC for a listing of Participating Employers and the coverage options available to You by Your Participating Employer.

The Plan is not a contract of employment between You and the GTCMHIC or any Participating Employer and does not give You the right to be retained in the service of the GTCMHIC or any Participating Employer. The GTCMHIC has the general right to amend or terminate the Plan, in whole or in part, at any time, subject to the approval of the New York State Superintendent of Financial Services.

If You are covered under the Blue Comprehensive option of the Plan, You have the option to receive Covered Services on two different benefit levels:

In-Network Benefits. In-network benefits are the highest level of coverage available. In-network benefits apply when Your care is provided by Participating Providers in the Network. You should always consider receiving health care services first through the in-network benefits portion of this Booklet.

Out-of-Network Benefits. Out-of-network benefits provide coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge. Some Covered Services, such as Prescription Drugs, are only Covered when received from Participating Providers and are not Covered as out-of-network benefits. See the Schedule of Benefits section of this Booklet for more information.

READ THIS ENTIRE BOOKLET CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER PLAN. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS BOOKLET.

If You need foreign language assistance to understand this Booklet, You may call the Claims Administrator at the number on Your ID card or Prescription Drug Benefit Manager (as applicable) at 877-635-9545.

Greater Tompkins County Municipal Health Insurance Consortium has adopted this Blue Comprehensive Option Benefit Booklet, effective as of January 1, 2023.

GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM

_____
Signature

Rordan Hart
Printed Name

GTCMHIC Chairperson
Title

_____
Dated

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SECTION I. DEFINITIONS

Defined terms will appear capitalized throughout this Booklet.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which the Plan payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Booklet for a description of how the Allowed Amount is calculated. If Your Non-Participating Provider charges more than the Allowed Amount, You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Appeal: A request for the Plan to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Child, Children: The Plan Participant's, Spouse's or Domestic Partner's:

- biological child;
- legally adopted child;
- child for whom You are the proposed adoptive parent and for which the child is dependent upon You during the waiting period prior to the adoption becoming final (or a child placed with You in anticipation of adoption);
- stepchild;
- child for whom You are a court-appointed legal guardian; or
- child for whom You are required to provide coverage under the Plan pursuant to the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN). Procedures for determining a QMCSO may be obtained from the GTCMHIC, upon request and free of charge.

For purposes of this section "a Child placed with You in anticipation of adoption" means a Child who is under the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by You of a legal obligation for total or partial support of the Child in anticipation of adoption of such Child.

Claims Administrator: Excellus Health Plan, Inc., doing business as Excellus BlueCross BlueShield ("Excellus BlueCross BlueShield"), administers claims for benefits under the Plan on behalf of the GTCMHIC and does not insure Your benefits. Excellus BlueCross BlueShield provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims. Excellus BlueCross BlueShield is a nonprofit independent licensee of the Blue Cross Blue Shield Association.

Claims Reviewer: With respect to benefits Covered under the medical sections of this Booklet, means the Claims Administrator. With respect to Prescription Drug Coverage

section of this Booklet, means the Prescription Drug Benefit Manager.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by the Plan under the terms and conditions of this Booklet.

Deductible: The amount You owe before the Plan begins to pay for most Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services.

Dependents: The Plan Participant's Spouse, Domestic Partner and eligible Children.

Domestic Partner: A Domestic Partner is a person of the same or opposite sex for which You submit the proof of domestic partnership and financial interdependence must be submitted in the form of:

(1) Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists; or

(2) For partners residing where registration does not exist, by:
   a. An alternative affidavit of domestic partnership. The affidavit must be notarized and must contain the following:
      - The partners are both 18 years of age or older and are mentally competent to consent to contract;
      - The partners are not related by blood in a manner that would bar marriage under applicable state law;
      - The partners have been living together on a continuous basis prior to the date of the application; and
      - Neither individual has been registered as a member of another domestic partnership within the last six (6) months;
   b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
   c. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
      - A joint bank account;
      - A joint credit card or charge card;
      - Joint obligation on a loan;
      - Status as an authorized signatory on the partner's bank account, credit card or charge card;

- Joint ownership of holdings or investments;
- Joint ownership of residence;
- Joint ownership of real estate other than residence;
- Listing of both partners as tenants on the lease of the shared residence;
- Shared rental payments of residence (need not be shared 50/50);
- Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
- A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
- Shared household budget for purposes of receiving government benefits;
- Status of one (1) as representative payee for the other's government benefits;
- Joint ownership of major items of personal property (e.g., appliances, furniture);
- Joint ownership of a motor vehicle;
- Joint responsibility for childcare (e.g., school documents, guardianship);
- Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
- Execution of wills naming each other as executor and/or beneficiary;
- Designation as beneficiary under the other's life insurance policy;
- Designation as beneficiary under the other's retirement benefits account;
- Mutual grant of durable power of attorney;
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

Durable Medical Equipment ("DME"): Equipment which is:
- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the

emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Exclusions: Health care services that the Plan does not pay for or Cover.

External Appeal Agent: An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under New York Public Health Law Article 36; a comprehensive care center for eating disorders pursuant to New York Mental Hygiene Law Article 30; and a Facility defined in New York Mental Hygiene Law Section 1.03, certified by the New York State Office of Addiction Services and Supports, or certified under New York Public Health Law Article 28 (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

Grievance: A complaint that You communicate to the Plan that does not involve a Utilization Review determination.

GTCMHIC: Greater Tompkins County Municipal Health Insurance Consortium.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitation Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; nurse practitioner; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be Covered under the Plan.

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to New York Public Health Law Article 40 or under a similar certification process

required by the state in which the hospice organization is located.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care. Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

Medically Necessary: See the How Your Coverage Works section of this Booklet for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Plan Participant or a covered Dependent that is enrolled in the Plan and that is covered under this Booklet. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

Mental Health Disorder. A Mental Health Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Network: The Providers that have contracted with Excellus BlueCross BlueShield or another Blue Cross and/or Blue Shield plan to provide health care services to You at a discounted rate.

Non-Participating Provider: A Provider who has not agreed to participate in the Network. You will pay more to see a Non-Participating Provider.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before the Plan begins to pay 100% of the Allowed Amount for Covered Services. This limit never includes Balance Billing charges or the cost of health care services the Plan does not Cover.

Participating Employer. Any county or municipality that has, with the consent of the GTCMHIC, adopted this Plan pursuant to a participation agreement by and between the GTCMHIC and the county or municipality for the exclusive benefit of its eligible employees and their eligible Dependents.

Participating Provider: A Provider who has agreed to participate in the Network and to provide health care services to You at a discounted rate. A list of Participating Providers and their locations is available at www.excellusbcbs.com or upon Your request, by contacting the customer service number listed in Your ID card. The list may be revised from time to time.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: Greater Tompkins County Municipal Cooperative Health Benefit Plan sponsored by the Greater Tompkins County Municipal Health Insurance Consortium, including the Schedule of Benefits, Benefit Booklets and any attached Amendment and Summary of Material Modifications.

Plan Participant: An employee of the GTCMHIC or a Participating Employer that is enrolled in the Plan and covered under this Booklet.

Plan Year: The 12-month period beginning on January 1 and ending on December 31.

Preauthorization: A decision by the Plan prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. Covered Services that require Preauthorization are indicated in the Schedule of Benefits section of this Booklet.

Prescription Drug Benefit Manager: ProAct, Inc.; 6333 Route 298, Suite 210, East Syracuse, NY 13057. Telephone No. 877-635-9545.

Prescription Drugs: A medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill and is on the Plan's formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Primary Care Physician ("PCP"): A participating Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional, Provider of Additional Health Services, or Facility licensed, registered, certified or accredited as required by state law.

Provider of Additional Health Services: A provider of services or supplies Covered under this Booklet (such as diabetic equipment and supplies, prosthetic devices or durable medical equipment) that is not a Facility or Health Care Professional, and that is licensed or certified according to applicable state law or regulation; approved by the applicable accreditation body, if any; and/or recognized by the Plan for payment under this Booklet.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Schedule of Benefits: The Medical Schedule of Benefit and Prescription Drug Schedule of Benefit sections of this Booklet, that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements, and other limits on Covered Services.

Service Area: The geographical area in which the Claims Administrator will arrange for and provide benefits to Members. The Service Area consists of: Broome; Cayuga; Chemung; Chenango; Clinton; Cortland; Delaware; Essex; Franklin; Fulton; Hamilton; Herkimer; Jefferson; Lewis; Livingston; Madison; Monroe; Montgomery; Oneida; Onondaga; Ontario; Oswego; Otsego; Schuyler; Seneca; Steuben; St. Lawrence; Tioga; Tompkins; Wayne; and Yates counties.

Skilled Nursing Facility: An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by the Plan to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The person to whom the Plan Participant is legally married, including a same sex Spouse.

Substance Use Disorder. A Substance Use Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

UCR (**Usual, Customary and Reasonable):** The amount paid for a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

Urgent Care Center: A licensed Facility (other than a Hospital) that provides Urgent Care.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

You, Your: The term “You” or “Your” refers to You, the Plan Participant. If family coverage applies, then in most cases the term “You” also includes any Dependents that are covered under this Booklet.

SECTION II. How Your Coverage Works

Covered Services.
You will receive Covered Services under the terms and conditions of this Booklet only when the Covered Service is:

- Medically Necessary;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Booklet; and
- Received while You are covered under the Plan.

Participating Providers.
To find out if a Provider is a Participating Provider:

- Check the Claims Administrator's Provider directory, available at Your request;
- Call the customer service number on Your ID card; or
- Visit www.excellusbcbs.com.

The Provider directory will give You the following information about Participating Providers:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken; and
- Whether the Participating Provider is accepting new patients.

You are only responsible for any Participating Provider Cost-Sharing that would apply to the Covered Services, if You receive Covered Services from a Provider who is not a Participating Provider in the following situations:

- The Provider is listed as a Participating Provider in the Claims Administrator's online Provider directory;
- The Claims Administrator's paper Provider directory listing the Provider as a Participating Provider is incorrect as of the date of publication;
- You were given written notice, by the Claims Administrator, that the Provider is a Participating Provider in response to Your telephone request for network status information about the Provider; or
- You are not provided with a written notice, by the Claims Administrator, within one (1) business day of Your telephone request for network status information.

In these situations, if a Provider bills You for more than Your Cost-Sharing for Participating Providers and You pay the bill, You are entitled to a refund from the Provider, plus interest.

The Role of Primary Care Physicians.
The Plan does not have a gatekeeper, usually known as a Primary Care Physician ("PCP"). You do not need a Referral from a PCP before receiving Specialist care.

However, You may need to request Preauthorization before You receive certain services. See the Schedule of Benefits section of this Booklet for the services that require Preauthorization.

Access to Providers and Changing Providers.
Sometimes Providers in the Provider directory are not available. You should call the Provider to make sure he or she is a Participating Provider and is accepting new patients.

To see a Provider, call his or her office and tell the Provider that You are a Member of a self-funded plan administered by Excellus BlueCross BlueShield, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Group or Member ID number. When You go to the Provider's office, bring Your ID card with You.

If there is not a Participating Provider in the Network for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, the Plan will approve an authorization to a specific Non-Participating Provider until You no longer need the care or until there is a Participating Provider in the Network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

Out-of-Network Services.
The Plan Covers services rendered by Non-Participating Providers. However, some services are only Covered when You go to a Participating Provider. See the Schedule of Benefits section of this Booklet for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

Services Subject to Preauthorization.
Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the Covered Services listed in the Schedule of Benefits section of this Booklet.

Preauthorization Procedure.
If You seek coverage for services that require Preauthorization, You must call the Claims Administrator at the number on Your ID card.

After receiving a request for approval, the Plan will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

Failure to Seek Preauthorization.
If You fail to seek Preauthorization for benefits subject to this section, the Plan will pay an amount of $500 less than it would otherwise have paid for the care, or 50% of the amount the Plan would otherwise have paid for the care, whichever results in a greater benefit for You. You must pay the remaining charges. The Plan will pay the amount specified above only if it determines the care was Medically Necessary even though You did not seek Preauthorization. If the Plan determines that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.

Medical Management.
The benefits available to You under this Booklet are subject to pre-service, concurrent and

retrospective reviews to determine when services should be Covered by the Plan. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

Medical Necessity.
The Plan Covers benefits described in this Booklet as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that the Plan is required to Cover it.

The Plan may base its decision on a review of:

- Your medical records;
- Medical policies and clinical guidelines of the Claims Administrator and/or Prescription Drug Benefit Manager (as applicable);
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, the Plan will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or in the home setting.

See the Utilization Review and External Appeal sections of this Booklet for Your right to an internal Appeal and external appeal of the Plan's determination that a service is not Medically Necessary.

Protection from Surprise Bills.

A. **Surprise Bills.** A surprise bill is a bill You receive for Covered Services in the following circumstances:

(1) For services performed by a Non-Participating Provider at a participating Hospital or Ambulatory Surgical Center, when:

- A Participating Provider is unavailable at the time the health care services are performed;
- A Non-Participating Provider performs services without Your knowledge; or
- Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a Participating Provider is available and You elected to receive services from a Non-Participating Provider.

(2) You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the referral is to a Non-Participating Provider and it may result in costs not covered by the Plan. For a surprise bill, a referral to a Non-Participating Provider means:

- Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;
- The participating Physician sends a specimen taken from You in the participating Physician's office to a non-participating laboratory or pathologist; or
- For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when referrals are required under the Plan.

You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your Participating Provider Cost-Sharing. The Non-Participating Provider may only bill You for Your Participating Provider Cost-Sharing. You can sign a form to notify the Claims Administrator and the Non-Participating Provider that You received a surprise bill.

The form for surprise bills is available at www.dfs.ny.gov or You can visit www.excellusbcbs.com for a copy of the form. You need to mail a copy of the form to the Claims Administrator at the address on Your ID card and to Your Provider.

B. **Independent Dispute Resolution Process.** Either the Plan or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity ("IDRE") assigned by the state. The IDRE will determine whether the Plan payment or the Provider's charge is reasonable within 30 days of receiving the dispute.

Delivery of Covered Services Using Telehealth.

If Your Provider offers Covered Services using telehealth, the Plan will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Booklet that are at least as favorable as those requirements for

the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies including telephone or video using smart phones or other devices, by a Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

Case Management.
The case management program ("Program") under the Plan helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The Program coordinates benefits and educates Members who agree to take part in the Program to help meet their health-related needs.

Participation in the Program is confidential and voluntary. The Program is given at no extra cost to You and do not change Covered Services. If You meet program criteria and agree to take part, the Program helps You meet Your identified health care needs. This is reached through contact and teamwork with You and/or Your authorized representative, treating Physician(s), and other Providers. In addition, the Program may assist in coordinating care with existing community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care through the Program that is not listed as a Covered Service. The Plan may also extend Covered Services beyond the benefit maximums listed in the Schedule of Benefits. The Plan will make a decision on a case-by-case basis if it determines the alternate or extended benefit is in the best interest of You and the Plan.

Nothing in this provision shall prevent You from appealing the Plan's decision. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to You or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Plan will notify You or Your representative in writing.

Important Telephone Numbers and Addresses.

- CLAIMS
  Medical Claims
  Refer to the address on Your ID card
  (Submit claim forms to this address.)

  https://member.excellusbcbs.com/claims/submission
  (Submit electronic claim forms to this web address.)

  Prescription Drug claims:
  Contact the Prescription Drug Benefits Manager at 877-635-9545 or
  www.proactrx.com

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  Medical Benefits:
  Call the customer service number on Your ID card

  Prescription Drug Benefits:
  Contact the Prescription Drug Benefits Manager at 877-635-9545

- SURPRISE BILL CERTIFICATION FORM
  Refer to the address on Your ID card
  (Submit surprise bill certification forms to this address.)

- MEMBER SERVICES
  Medical Benefits:
  Call the customer service number on Your ID card
  (Member Services Representatives are available Monday - Friday)

  Prescription Drug Benefits:
  Contact the Prescription Drug Benefits Manager at 877-635-9545

- PREAUTHORIZATION
  Medical Benefits:
  Call the phone number on Your ID card

  Prescription Drug Benefits:
  Contact the Prescription Drug Benefits Manager at 877-635-9545

- CLAIMS ADMINISTRATOR'S WEBSITE
  www.excellusbcbs.com

- PRESCRIPTION DRUG BENEFITS MANAGER'S WEBSITE
  www.proactrx.com

SECTION III. Access to Care and Transitional Care

Authorization to a Non-Participating Provider.
If the Plan does not have a Participating Provider that has the appropriate training and experience to treat Your condition, the Plan will approve an authorization to an appropriate Non-Participating Provider. Your Participating Provider or You must request prior approval of the authorization to a specific Non-Participating Provider. Approvals of authorizations to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If the Plan approves the authorization, all services performed by the Non-Participating Provider are subject to a treatment plan approved by the Plan in consultation with Your PCP, the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be Covered as if they were provided by a Participating Provider. You will be responsible only for any applicable Participating Provider Cost-Sharing. In the event an authorization is not approved, any services rendered by a Non-Participating Provider will be Covered at the Non-Participating Provider benefit level, if available.

When Your Provider Leaves the Network.
If You are in an ongoing course of treatment when Your Provider leaves the Network, then You may continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant, You may continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

The Provider must accept as payment the negotiated fee that was in effect just prior to the termination of the relationship of the Provider with the Network. The Provider must also provide the Plan with necessary medical information related to Your care and adhere to any policies and procedures of the Plan, including those for assuring quality of care, and obtaining Preauthorization and a treatment plan approved by the Plan. You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable Participating Provider Cost-Sharing.

In addition to the above, if You are considered a "continuing care patient" and any benefits under the Plan are terminated because of a change in the terms of participation of Your Provider in the Network, You will be given notice of such change or termination and will have the right to elect to continue coverage under the Plan, with respect to that Provider, under the same terms and conditions that were in effect on the date You are given notice of the Provider's change in Network status or termination of benefits as a results of a change in Network participation. If You elect to continue such coverage under the Plan, coverage for transitional care with respect to that Provider will be provided under those same terms and conditions only for the period ending on the earlier of (1) 90 days from the date the notice is provided or (2) the date You are no longer considered a "continuing care patient". In addition, coverage under those same terms and conditions during this period of transitional care is limited to the condition for which You were receiving care from Your Provider, that qualifies You as a "continuing care patient", prior to the Provider's change in Network status.

For purposes of this section, You are a "continuing care patient" if You meet any of the following conditions:

(1) You are undergoing a course of treatment for a serious and complex condition. Serious and complex condition means:

a. An acute illness that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
b. A chronic illness that is life threatening, degenerative, potentially disabling or congenital and requires specialized medical care for a prolonged period of time.

(2) Undergoing a course of institutional or inpatient care from the Provider.
(3) You are scheduled to undergo non-elective surgery, including post-operative care from the Provider.
(4) You are pregnant and undergoing a course of treatment for the pregnancy from the Provider.
(5) You are terminally ill (as defined in Section 1861 of the Social Security Act) and receiving treatment for the terminal illness from the Provider.

Please note, if the Provider was terminated by the Network due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

If You have any questions with respect to this provision, please contact Your Plan Administrator or the Claims Administrator at the telephone number listed on Your identification card.

New Members in a Course of Treatment.
If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Booklet becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of Your coverage under this Booklet. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this Booklet becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

For You to continue to receive Covered Services for up to 60 days or through pregnancy, the Non-Participating Provider must agree to accept as payment for such services the fees the Plan would have reimbursed had the Provider been a Participating Provider. The Provider must also agree to provide the Plan necessary medical information related to Your care and to adhere to any applicable policies and procedures including those for assuring quality of care and obtaining Preauthorization, and a treatment plan approved by the Plan. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable Participating Provider Cost-Sharing.

SECTION IV. Cost-Sharing Expenses and Allowed Amount

Deductible.
Except where stated otherwise, You must pay the amount in the Schedule of Benefits sections of this Booklet for Covered Services during each Plan Year before the Plan will provide coverage.

Copayments.
Except where stated otherwise, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits sections of this Booklet for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

Coinsurance.
Except where stated otherwise, You must pay a percentage of the Allowed Amount for Covered Services as specified in the Schedule of Benefits sections of this Booklet.

Out-of-Pocket Limit.
When You have met Your Out-of-Pocket Limit in payment of Cost-Sharing for a Plan Year as specified in the Schedule of Benefits sections of this Booklet, the Plan will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year.

The following charges/penalties are Your responsibility and do not apply toward Your Out-of-Pocket Limit:

- **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**
- **The Preauthorization penalty described in the How Your Coverage Works section of this Booklet.**
- **Services or charges not Covered by the Plan.**

Your Additional Payments for Out-of-Network Benefits.
When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Cost-Sharing described in the Schedule of Benefits section of this Booklet, You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds the Allowed Amount. This means that the total of the Plan's coverage and any Cost-Sharing amounts You pay may be less than the Non-Participating Provider's actual charge.

When You receive Covered Services from a Non-Participating Provider, the Plan will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that the Plan pays for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. The Plan will make one (1) inclusive payment in that case, rather than a separate payment for each billed code. Another example of when the Plan will apply the payment rules to a claim is when You have surgery that involves two (2) surgeons acting as "co-surgeons". Under the payment rules, the claim from each Provider should have a "modifier" on it that identifies it as coming from a

co-surgeon. If the Plan receives a claim that does not have the correct modifier, the Plan will change it and make the appropriate payment.

Allowed Amount.
"Allowed Amount" means the maximum amount the Plan will pay for services or supplies Covered under this Plan, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. The Allowed Amount is determined as follows:

A. **Prescription Drug Benefits.** The Allowed Amount for Prescription Drug benefits under the Plan from a Participating Pharmacy is the Prescription Drug Cost before any applicable Coinsurance, Copayment and Deductible Amounts are subtracted. To the extent the Allowed Amount is less than Your Copayment, You will pay the Allowed Amount.

B. **Medical Benefits.** The Allowed Amount for medical benefits under the Plan from Participating Providers will be determined as follows:

(1) **Participating Facilities in the Service Area**.
For a participating Facility in the Service Area, the Allowed Amount will be the amount the Plan has have negotiated with the Facility.

(2) **For All Other Participating Providers in the Service Area**.
For all other Participating Providers in the Service Area, the Allowed Amount will be the amount the Plan has negotiated with the Participating Provider.

(3) **Participating Facilities Outside the Service Area.**
For a participating Facility outside the Service Area, the Allowed Amount will be the amount the Plan has negotiated with the Facility or the amount approved by another Blue Cross and/or Blue Shield plan.

(4) **For All Other Participating Providers Outside the Service Area.**
For all other Participating Providers outside the Service Area, the Allowed Amount will be the amount the Plan has negotiated with the Participating Provider or the amount approved by another Blue Cross and/or Blue Shield plan.

When the Participating Provider's charge is less than the amount the Plan has negotiated with the Participating Provider, Your Copayment, Deductible or Coinsurance amount will be based on the Participating Provider's charge.

The Plan's payments to Participating Providers may include financial incentives to help improve the quality or coordination of care and promote the delivery of Covered Services in a cost-efficient manner. Payments under this financial incentive program are not made as payment for a specific Covered Service provided to You. Your Cost-Sharing will not change based on any payments made to or received from Participating Providers as part of the financial incentive program.

The Allowed Amount for Non-Participating Providers will be determined as follows:

(1) **Facilities in the Service Area.**
For Facilities in the Service Area, the Allowed Amount will be the Facility's

charge.

(2) **Facilities Outside the Service Area.**
For Facilities outside the Service Area, the Allowed Amount will be the Facility's charge.

(3) **For a Health Care Professional or a Provider of Additional Health Services in the Service Area.**
For a Health Care Professional or a Provider of Additional Health Services in the Service Area, the Allowed Amount will be the Centers for Medicare and Medicaid Services Provider ("CMMSP") fee schedule, as applicable to the provider type unadjusted for geographic locality, or the Non-Participating Providers charge, if less.

If there is no CMMSP amount, as described above, the Allowed Amount will be 75% of the Non-Participating Providers charge.

(4) **For a Health Care Professional or a Provider of Additional Health Services Outside the Service Area.**
For a Health Care Professional or a Provider of Additional Health Services outside the Service Area, the Allowed Amount will be 150% of the Centers for Medicare and Medicaid Services Provider ("CMMSP") fee schedule, as applicable to the provider type unadjusted for geographic locality, or the Non-Participating Providers charge, if less.

If there is no CMMSP amount, as described above, the Allowed Amount will be 75% of the Non-Participating Providers charge.

(5) **Ground Ambulance in the Service Area.** The Allowed Amount for ground ambulance in the Service Area will be the 80th percentile of the Usual, Customary and Reasonable (UCR) rate or charge (as supplied by FAIR Health) or the Provider's charge, if less.

(6) **Ground Ambulance outside the Service Area.**

a. **New York State.** The Allowed Amount for ground ambulance outside the Service Area for services rendered in New York State will be the 80th percentile of the Usual, Customary and Reasonable (UCR) rate or charge (as supplied by FAIR Health) or the Provider's charge, if less.

b. **Outside of New York State.** The Allowed Amount for ground ambulance outside the Service Area for services rendered outside of New York State will be 100% of the Provider's charge.

(7) **Surprise Bills.** The Allowed Amount for surprise bills for a Non-Participating Provider will be the lesser of the Non-Participating Provider's charge or the "qualifying payment amount". Please refer to the section of this Booklet entitled "Protection from Surprise Bills" for what constitutes a surprise bill and for how the "qualifying payment amount" is determined.

(8) **In Vitro Diagnostic Test for the Detection of SARS-CoV-2.** Effective as of March 13, 2020 and until May 11,2023, the Allowed Amount for a Non-

Participating Provider for an in vitro diagnostic test for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 is the Non-Participating Provider's publicly listed price for such test, or such lower rate as the Claims Administrator may negotiate with the Non-Participating Provider. Effective as of May 12, 2023, the Allowed Amount for a Non-Participating Provider for an in vitro diagnostic test for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 will be determined in accordance with (1) through (4) above, as applicable.

(9) **Physician-Administered Pharmaceuticals.**
For Physician-administered pharmaceuticals, the Plan uses methodologies that are similar to the pricing methodology used by the Centers for Medicare and Medicaid Services, and produce fees based on published acquisition costs or Average Wholesale Price for the pharmaceuticals. These methodologies are currently created by the Plan and reviewed on a periodic basis to ensure the appropriate payment methodology is assigned to all drugs. Pricing resources can include references such as IPD Analytics, Medispan, First Data Bank, or Thomson Reuters (published in its Red Book).

The Non-Participating Provider's actual charge may exceed the Allowed Amount. You must pay the difference between the Allowed Amount and the Non-Participating Provider's charge. Contact the Claims Administrator at the number on Your ID card or visit www.excellusbcbs.com for information on Your financial responsibility when You receive services from a Non-Participating Provider.

The Plan reserve the right to negotiate a lower rate with Non-Participating Providers or to pay a Blue Cross and/or Blue Shield host plan's rate, if lower.

SECTION V. Who is Covered

Who is Covered Under this Booklet.
Subject to the permissible eligibility rules of the Participating Employer at which You are employed, You, the Plan Participant to whom this Booklet is issued, are covered under this Booklet and, if You selected family coverage, the following Dependents may also be covered:

(1) Your Spouse.

(2) Your Domestic Partner.

(3) Your Child until the end of the month in which the Child turns age 26.

(4) Your unmarried Child age 26 or older who is incapable of self-sustaining employment by reason of mental illness, developmental disability, intellectual disability (as defined in the New York Mental Hygiene Law or other applicable state law), or physical disability and who became so incapable prior to end of the month in which the Child attained age 26. Your Child must be chiefly dependent upon You, Your Spouse or Domestic Partner for support and maintenance.

You have 31 days from the end of the month in which Your Child attains age 26 to provide proof of the Child's incapacity and to enroll such Child or request continued coverage for such Child under this Plan. The Claims Administrator or the Plan may request subsequent proof of Your Child's incapacity and eligibility for coverage under the Plan pursuant to this provision.

The Claims Administrator and the Plan have the right to request and be furnished with such proof as may be needed to determine whether a Dependent meets the eligibility requirements for coverage under the Plan at any time.

Types of Coverage.
The Plan offers the following types of coverage:

(1) **Individual.** If You, the Plan Participant, selected individual coverage when You enrolled, then You are covered under the Plan.

(2) **Family.** If You, the Plan Participant, selected family coverage when You enrolled, then You, Your Spouse or Domestic Partner and Your dependent Child or Children that You included on Your enrollment form are covered under the Plan.

When Coverage Begins.
Coverage under the Plan will begin as follows:

(1) If You, the Plan Participant, elect coverage before becoming eligible, or within 30 days of becoming eligible, other than through a special enrollment period, coverage begins on the date You become eligible.

(2) If You, the Plan Participant, do not elect coverage upon becoming eligible or within 30 days of becoming eligible, other than through a special enrollment period, You must wait until the Participating Employer's next open enrollment period to enroll, except as provided in the "Special Enrollment Periods" section below.

Special Enrollment Periods.
Note: This provision is extended to coverage of Domestic Partners and to Children of a Domestic Partner.
You, the Plan Participant, may make a mid-year change in Your election as a result of any of the following special enrollment events:

(1) **Loss of Other Coverage.** You previously declined coverage for yourself and/or Your eligible Dependents because You and/or Your Dependents had other health coverage when You were initially eligible, but that other health coverage was lost as a result of one of the following events:

a. Legal separation, divorce, death, loss of Dependent status, termination of employment, reduction in hours, or any other reason required by HIPAA;

b. The other health coverage was COBRA and the maximum continuation period available under COBRA has been exhausted; or

c. Employer contributions for the other health coverage ended.

If You and/or Your Dependent lost the other health coverage for reasons of non-payment of the required contribution or premium, making a fraudulent claim or an intentional misrepresentation of material fact, then You and/or Your Dependents will not be eligible to take advantage of this special enrollment right and enroll in the Plan mid-year.

If You, the Plan Participant, are the one that loses the other health coverage, You may enroll yourself and any eligible Dependents in the Plan. If Your eligible Dependent loses the other health coverage, and You are already enrolled in the Plan, You may enroll Your Dependent in that same benefit option You are already enrolled in or You may enroll in a different benefit option available under the Plan due to the special enrollment event of Your Dependent.

You must request enrollment in the Plan by submitting any required enrollment and election forms to Your Participating Employer no later than 30-days after the date Your other health coverage was lost. Coverage under the Plan will begin as of the first day of the month following the date You request enrollment. Failure to enroll in the Plan will result in no coverage under the Plan. You may elect to enroll in the Plan again during the Participating Employer's next open enrollment period, or in the event You experience another special enrollment or change in status event.

(2) **Acquisition of a New Dependent.** You declined to enroll, failed to enroll or enrolled in individual-only coverage under the Plan when You were initially eligible or during the Participating Employer's open enrollment period and You acquire a new Dependent mid-year as a result of marriage or entering into a domestic partnership, birth, adoption or placement for adoption.

You must request enrollment in the Plan by submitting any required enrollment and election forms to Your Participating Employer no later than 30-days after the date of the event. Coverage under the Plan will begin as follows:

a. For a newborn Child (other than a proposed adopted newborn Child), coverage

will begin as of the date of birth, provided You request enrollment within the 30-day period described above.

b. For a proposed adopted newborn Child, coverage will begin as of the date of birth, provided You request enrollment within the 30-day period described above; and

(i) You take physical custody of the newborn as soon as the Child is released from the Hospital after birth; and
(ii) File a petition for adoption pursuant to applicable state law within 30 days after the Child's birth.

Coverage under the Plan will not be provided for the proposed adopted newborn Child if a notice of revocation of the adoption has been filed (pursuant to applicable state law) or one of the natural parents revokes consent to the adoption. If the Plan provides coverage of a proposed adopted newborn Child, and notice of the revocation of the adoption is filed or one of the natural parents revokes their consent, the Plan will be entitled to recover any sums paid by it for care of the proposed adopted newborn Child.

c. For an adopted Child (or Child placed with You in anticipation of adoption), coverage will begin as of the date of adoption (or placement for adoption), provided You request enrollment within the 30-day period described above.

d. For a newly acquired Dependent as a result of marriage or entering into a domestic partnership, coverage will begin as of the date of marriage or domestic partnership, provided You request enrollment within the 30-day period described above.

Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan. You may elect to enroll in the Plan again during the Participating Employer's next open enrollment period, or in the event You experience another special enrollment or change in status event.

(3) **Eligibility Changes in Medicaid and State Child Health Insurance Programs (SCHIP).** You declined or failed to enroll in coverage under the Plan when You were initially eligible because:

a. You or Your Dependent were covered under Medicaid or a SCHIP at the time You were initially eligible, but now Your or Your Dependent's coverage under Medicaid or a SCHIP has terminated due to loss of eligibility for such coverage; or

b. You or Your Dependent became eligible for a state premium assistance subsidy under Medicaid or SCHIP to assist with payment of any required employee contribution under the Plan.

Coverage under the Plan will begin as of the first day of the month following the date You request enrollment in the Plan, provided such request is made within 60-days after coverage under Medicaid or SCHIP terminates or You become eligible for a state premium assistance subsidy.

Failure to enroll in the Plan within the 60-day period described above will result in no

coverage under the Plan. You may elect to enroll in the Plan again during the Participating Employer's next open enrollment period, or in the event You experience another special enrollment or change in status event.

Change in Election Due to Marketplace Coverage

If You have an opportunity to enroll in a qualified health plan through an exchange or marketplace established under the Affordable Care Act ("Marketplace Coverage"), You may change Your benefit elections under this Plan to cancel medical coverage under this Plan but only if You (and all Dependents whose coverage under this Plan is being cancelled) are also enrolling in Marketplace Coverage. Cancelling coverage under this Plan based on this rule will be permitted only if the Marketplace Coverage (for all Members whose coverage under this Plan is being cancelled) is effective no later than the next day after coverage under this Plan would terminate because of the cancellation of coverage. The Plan may rely on Your reasonable representation that all Members whose coverage is being cancelled have enrolled in or will enroll in Marketplace Coverage to be effective no later than the deadline indicated in the previous sentence, but the GTCMHIC or Participating Employer, in its discretion, may also require additional documentation of the Marketplace Coverage. Also, note that You are permitted to enroll in Marketplace Coverage only during the annual Marketplace enrollment period or based on a marketplace special enrollment opportunity. Details about the enrollment periods for Marketplace Coverage are available at: https://nystateofhealth.ny.gov/.

SECTION VI . Preventive Care

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

Preventive Care.
The Plan Covers the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact the Claims Administrator at the number on Your ID card or visit www.excellusbcbs.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

A. **Well-Baby and Well-Child Care.** The Plan Covers well-baby and well-childcare which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. The Plan also Covers preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per Plan Year, the Plan will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as recommended by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Copayments, Deductibles or Coinsurance when rendered by a Participating Provider.

B. **Adult Annual Physical Examinations.** The Plan Covers adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

   Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening, and diabetes screening. A complete list of the Covered preventive Services is available at www.excellusbcbs.com, or will be mailed to You upon request.

   The Plan will not provide coverage for any service or care related to a routine physical examination and/or testing to certify health status, including, but not limited to, an examination required for school, employment, insurance, marriage, licensing, travel, camp, sport or adoption, unless the service is Covered under the terms of this Booklet.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

C. **Adult Immunizations.** The Plan Covers adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

D. **Well-Woman Examinations.** The Plan Covers well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating cervical cancer screening tests. The Plan also Covers preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive services is available at www.excellusbcbs.com, or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above and when provided by a Participating Provider.

E. **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer.** The Plan Covers screening and diagnostic imaging for the detection of breast cancer, including screening and diagnostic mammograms (which may be provided by breast tomosynthesis (i.e., 3D mammograms)), breast ultrasounds and MRIs.

F. **Family Planning and Reproductive Health Services.** The Plan Covers family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider not otherwise Covered under the Prescription Drug Coverage section of this Booklet; patient education and counseling on use of contraceptives and related topics; follow-up services related to contraceptive methods, including management of side effects, counseling for continued adherence, and device insertion and removal; and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

The Plan also Covers vasectomies subject to Cost-Sharing specified in the Schedule of Benefits.

The Plan does not Cover services related to the reversal of elective sterilizations.

G. **Bone Mineral Density Measurements or Testing.** The Plan Covers bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug Coverage section of this Booklet. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program or those in accordance with the criteria of the National Institutes of Health. You will qualify for Coverage if You meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health or if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

The Plan also Covers osteoporosis screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Copayments, Deductibles or Coinsurance when rendered by a Participating Provider and when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices.

H. **Screening for Prostate Cancer.** The Plan Covers an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. The Plan also Covers standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

I. **Colonoscopies.** The Plan Covers colonoscopies to screen for colon cancer in asymptomatic Members according to the preventive care guidelines when not subject to the comprehensive guidelines supported by USPSTF.

Diagnostic colonoscopies (colonoscopies that are performed in connection with the treatment or follow-up of colon cancer) are unlimited and are Covered whenever they are Medically Necessary. Diagnostic colonoscopies may be subject to Copayments, Deductibles or Coinsurance.

Screening colonoscopies are not subject to Copayments, Deductibles or Coinsurance when rendered by a Participating Provider and provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

J. **Preventive Services.** The Plan will provide coverage for the preventive services identified below without Cost-Sharing when rendered by a Participating Provider.

(1) **Evidence-Based Preventive Services.** Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") with respect to the individual involved, except that with respect to breast cancer screening, mammography and prevention of breast cancer, the recommendations of the USPSTF issued in 2002

will be considered the current recommendations until further guidance is issued by the USPSTF or the Health Resources and Services Administration ("HRSA");

(2) **Routine Immunizations.** Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention with respect to the individual involved;

(3) **Prevention for Children.** With respect to infants, Children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by HRSA; and

(4) **Prevention for Women.** With respect to women, such additional preventive care and screenings, not otherwise addressed by the USPSTF, as provided for in comprehensive guidelines supported by HRSA and published on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services).

(5) **COVID-19 Vaccine:** Effective as of 15 business days after a recommendation is made from the United States Preventive Services Task Force or CDC Advisory Committee on Immunization Practices, the Plan will provide coverage for vaccines and other services intended to prevent COVID-19.

To the extent they are not already Covered Services for women under this Plan, benefits will be provided for all FDA-approved sterilization procedures and generic contraceptive methods. FDA-approved contraceptive methods include prescription drugs, devices and over-the-counter contraceptives when prescribed by a provider legally authorized to prescribe. Coverage for brand name contraceptive methods will also be provided; but only if no generic equivalent is available or the generic equivalent is medically inappropriate for the Member, as determined by a Health Care Professional acting within the scope of his or her license.

A list of the preventive services Covered under this paragraph is available on the Claims Administrator's website at www.excellusbcbs.com or the Prescription Drug Benefit Manager's website at www.proactrx.com or will be mailed to You upon request. You may request the list by calling the Claims Administrator at the number on Your ID card or the Prescription Drug Benefit Manager at 877-635-9545.

SECTION VII. Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

Emergency Ambulance Transportation.

A. **Pre-Hospital Emergency Medical Services.** The Plan Covers Pre-Hospital Emergency Medical Services worldwide for the treatment of an Emergency Condition when such services are provided by an ambulance service.

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the New York Public Health Law. The Plan will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

B. **Emergency Ambulance Transportation.** In addition to Pre-Hospital Emergency Medical Services, the Plan also Covers emergency ambulance transportation worldwide by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency ambulance transportation to a Hospital when the originating Facility does not have the ability to treat Your Emergency Condition.

C. **Non-Emergency Ambulance Transportation.**

The Plan Covers non-emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a Non-Participating Provider Hospital to a Participating Provider Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care Facility; or
- From an Acute care Facility to a sub-Acute setting.

D. **Limitations/Terms of Coverage.**

- The Plan does not Cover travel or transportation expenses unless connected to an Emergency Condition or due to a Facility transfer approved the Plan, even though prescribed by a Physician.
- The Plan does do not Cover non-ambulance transportation such as ambulette, van or taxicab.
- Coverage for air or water ambulance related to an Emergency Condition or air or water ambulance related to non-emergency transportation is provided to the nearest Facility when Your medical condition is such that transportation by land ambulance is not appropriate; **and** Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance**; and** one (1) of the following is met:
    - The point of pick-up is inaccessible by land vehicle; or
    - Great distances or other obstacles (e.g. heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

E. **Payments for Air Ambulance Services.** The Plan will pay a Non-Participating Provider the "qualifying" payment amount" under applicable rules regarding "surprise bills". If a dispute involving a payment for air ambulance services is submitted to an independent dispute resolution entity (IDRE), the Plan will pay the amount, if any, determined by the IDRE for the air ambulance services.

You are responsible for any Cost-Sharing applicable to Participating Providers for air ambulance services. The Non-Participating Provider may only bill You for the Cost-Sharing applicable to Participating Providers. If You receive a bill from a Non-Participating Provider that is more than Your Participating Provider Cost-Sharing, You should contact the Claims Administrator at the number on Your ID card. Visit www.excellusbcbs.com or www.dfs.ny.gov for more information on the independent dispute resolution process for air ambulance bills.

SECTION VIII. Emergency Services and Urgent Care

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

A. **Emergency Services.**
The Plan Covers Emergency Services for the treatment of an Emergency Condition in a Hospital.

Emergency Conditions may include, but are not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. The Plan will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, the Plan will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital.

Please follow the instructions listed below regardless of whether or not You are in the Service Area at the time Your Emergency Condition occurs:

1. **Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization.

   The Plan also provides coverage at a Hospital emergency department for non-Emergency Conditions; however, the Plan does not Cover follow-up care or routine care provided in a Hospital emergency department.

2. **Emergency Hospital Admissions**. The Plan Covers inpatient Hospital services following Emergency Department Care at a Non-Participating Provider Hospital subject to the Participating Provider Cost-Sharing. If Your medical condition permits Your transfer to a participating Hospital, You will be notified and the transfer will be arranged.

3. **Payments Relating to Emergency Services.** The Plan will pay a Non-Participating Provider the “qualifying” payment amount” under applicable rules regarding “surprise bills”. If a dispute involving a payment for air ambulance

services is submitted to an independent dispute resolution entity (IDRE), the Plan will pay the amount, if any, determined by the IDRE for the air ambulance services.

You are responsible for any Participating Provider Cost-Sharing. You will be held harmless for any Non-Participating Provider charges that exceed Your Participating Provider Cost-Sharing. The Non-Participating Provider may only bill You for Your Participating Provider Cost-Sharing. If You receive a bill from a Non-Participating Provider that is more than Your Participating Cost-Sharing, You should contact the Claims Administrator. Visit www.excellusbcbs.com or www.dfs.ny.gov for more information on the independent dispute resolution process for Emergency Services.

B. **Urgent Care.**

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care is typically available after normal business hours, including evenings and weekends. If You need care after normal business hours, including evenings, weekends or holidays, You have options. You can call Your Provider's office for instructions or visit an Urgent Care Center. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911.

SECTION IX. Outpatient and Professional Services

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

Advanced Imaging Services. The Plan Covers PET scans, MRI, nuclear medicine, and CAT scans.

Allergy Testing and Treatment. The Plan Covers testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. The Plan also Covers allergy treatment, including desensitization treatments, routine allergy injections and serums.

Ambulatory Surgical Center Services. The Plan Covers surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed.

Chemotherapy and Immunotherapy. The Plan Covers chemotherapy and immunotherapy in an outpatient Facility or in a Health Care Professional's office. Chemotherapy and immunotherapy may be administered by injection or infusion. Orally-administered anti-cancer drugs are Covered under the Prescription Drug Coverage section of this Booklet.

Chiropractic Services. The Plan Covers chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be Covered in accordance with the terms and conditions of this Booklet.

Clinical Trials. The Plan Covers routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and the External Appeal sections of this Booklet.

The Plan does not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this Booklet for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II III, or IV clinical trial that is:

- A federally funded or approved trial;

- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

Dialysis. The Plan Covers dialysis treatments of an Acute or chronic kidney ailment.

Habilitation Services. The Plan Covers Habilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office. Any visit limit applies to all therapies combined.

Home Health Care. The Plan Covers care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes:

- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide;
- Physical, occupational or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription Drugs and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Infertility Treatment. The Plan Covers services for the diagnosis and treatment (surgical and medical) of infertility. "Infertility" is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. Earlier evaluation and treatment may be warranted based on a Member's medical history or physical findings.

Such Coverage is available as follows:

A. **Basic Infertility Services.** Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, the Plan will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York.

Basic infertility services include:
- Initial evaluation;
- Semen analysis;
- Laboratory evaluation;
- Evaluation of ovulatory function;
- Postcoital test;
- Endometrial biopsy;
- Pelvic ultrasound;
- Hysterosalpingogram;

- Sono-hystogram;
- Testis biopsy;
- Blood tests; and
- Medically appropriate treatment of ovulatory dysfunction.

Additional tests may be Covered if the tests are determined to be Medically Necessary.

B. **Comprehensive Infertility Services**. If the basic infertility services do not result in increased fertility, the Plan Covers comprehensive infertility services.

Comprehensive infertility services include:
- Ovulation induction and monitoring;
- Pelvic ultrasound;
- Artificial insemination;
- Hysteroscopy;
- Laparoscopy; and
- Laparotomy.

C. **Advanced Infertility Services.** The Plan Covers the following advanced infertility services:

- Three (3) cycles per lifetime of in vitro fertilization; and
- Cryopreservation and storage of sperm, ova, and embryos in connection with in vitro fertilization.

"Lifetime" for purposes of this section, means during Your lifetime while You are covered under the Plan

A "cycle" is all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in vitro fertilization using a fresh embryo transfer, or medications are administered for endometrial preparation with the intent of undergoing in vitro fertilization using a frozen embryo transfer.

D. **Fertility Preservation Services.** The Plan Covers standard fertility preservation services when a medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm. "Iatrogenic infertility" means an impairment of Your fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

E. **Exclusions and Limitations.** The Plan does not Cover:
- Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
- Costs associated with an ovum or sperm donor, including the donor's medical expenses;
- Ovulation predictor kits;
- Reversal of tubal ligations;
- Reversal of vasectomies;

- Costs for services relating to surrogate motherhood that are not otherwise Covered Services under this Booklet;
- Cloning; or
- Medical and surgical procedures that are experimental or investigational, unless the Plan's denial is overturned by an External Appeal Agent.

All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine. The Plan will not discriminate based on Your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity, when determining coverage under this benefit.

Infusion Therapy. The Plan Covers infusion therapy which is the administration of drugs using specialized delivery systems. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected into the muscles are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy as part of a primary service (such as chemotherapy, radiation therapy and home health care).

Interruption of Pregnancy. The Plan Covers elective abortions and Medically Necessary abortions including abortions in cases of rape, incest or fetal malformation.

In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the Virus that causes COVID-19.

A. Effective as of March 13, 2020 up to and including May 11, 2023, the Plan will provide coverage for an in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and the administration of such a test for members suspected of a COVID-19 infection, or suspected of having recovered from COVID-19 infection, that—

- is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k), 360c, 360e, 360bbb–3);

- the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

- is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID–19; or

- other tests that the Secretary determines appropriate in guidance.

and which have been determined to be medically appropriate for You by Your attending

provider. In addition to the above, the Plan will provide coverage for any items and services provided during an office visit (including telehealth), urgent care center visit, or emergency room visit that relates to the furnishing or administration of the test or to the evaluation of the individual for purposes of determining the need for the test; and results in an order for or administration of such test. Such coverage will be provided when rendered by a Participating Provider or Non-Participating Provider and will not be subject to any Cost-Sharing (i.e. Coinsurance, Copayments or Deductibles), Preauthorization requirements or any other medical management requirements. Other services that You may receive during such a visit that are not related to determining the need for a test or administration of a test, will be subject to the normal Plan Cost-Sharing, Preauthorization and medical management requirements.

B. Effective as of May 12, 2023, the Plan will provide coverage for an in vitro diagnostic test defined in section 809.3 of title 21, Code of Federal Regulations (or successor regulations) for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19, and the administration of such a test for members suspected of a COVID-19 infection, or suspected of having recovered from COVID-19 infection, that—

- is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(k), 360c, 360e, 360bbb–3);

- the developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;

- is developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID–19; or

- other tests that the Secretary determines appropriate in guidance.

and which have been determined to be medically appropriate for You by Your attending provider.

In addition to the above, the Plan will provide coverage for any items and services provided during an office visit (including telehealth), urgent care center visit, or emergency room visit that relates to the furnishing or administration of the test or to the evaluation of the individual for purposes of determining the need for the test; and results in an order for or administration of such test. Such coverage will be provided when rendered by a Participating Provider or Non-Participating Provider. Such coverage will be subject to the same Cost-Sharing (i.e. Coinsurance, Copayments or Deductibles) that is applicable to any other lab or diagnostic test Covered under the Plan. Telehealth and any emergency room, urgent care center or office visits that are associated with such diagnostic testing will be subject to the same Cost-Sharing that applies to all other telehealth, emergency room, urgent care center or office visits under the Plan. Preauthorization requirements or any other medical management requirements may apply.

Laboratory Procedures, Diagnostic Testing and Radiology Services. The Plan Covers x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

Maternity and Newborn Care. The Plan Covers services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. The Plan Covers prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. For services of a midwife to be Covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. The Plan will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Booklet of inpatient maternity care.

The Plan Covers breastfeeding support, counseling and supplies, including the cost of renting or the purchase of one (1) breast pump per pregnancy.

Office Visits. The Plan Covers office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.

Outpatient Hospital Services. The Plan Covers Hospital services and supplies as described in the Inpatient Services section of this Booklet that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.

Preadmission Testing. The Plan Covers preadmission testing ordered by Your Physician and performed in Hospital outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests; and
- The patient is physically present at the Hospital for the tests.

Prescription Drugs for Use in the Office and Outpatient Facilities. The Plan Covers Prescription Drugs (excluding self-injectable drugs) used by Your Provider in the Provider's office and Outpatient Facility for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Booklet. .

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a participating Specialist) in order to arrange for additional care for a Member.

Rehabilitation Services. The Plan Covers Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office.

Second Opinions.

A. **Second Cancer Opinion.** The Plan Covers a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.

B. **Second Surgical Opinion.** The Plan Covers a second surgical opinion by a qualified Physician on the need for surgery.

C. **Second Opinions in Other Cases.** There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that the Plan designate another Provider to render a second opinion. If the first and second opinions do not agree, the Plan will designate another Provider to render a third opinion. After completion of the second opinion process, the Plan will approve Covered Services supported by a majority of the Providers reviewing Your case

Surgical Services. The Plan Covers Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure when rendered by the surgeon or the surgeon's assistant.

Benefits also include the initial prescription for standard contact lenses or standard lenses and standard frames after cataract surgery.

Sometimes two (2) or more surgical procedures can be performed during the same operation.

A. **Through the Same Incision.** If Covered multiple surgical procedures are performed through the same incision, the Plan will pay for the procedure with the highest Allowed Amount and 50% of the amount the Plan would otherwise pay for the secondary procedures, except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions. The Plan will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to the primary procedure.

B. **Through Different Incisions.** If Covered multiple surgical procedures are performed during the same operative session but through different incisions, the Plan will pay:

- For the procedure with the highest Allowed Amount; and
- 50% of the amount the Plan would otherwise pay for the other procedures.

Oral Surgery. The Plan will Cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental

injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

Reconstructive Breast Surgery. The Plan Covers breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. The Plan also Covers implanted breast prostheses following a mastectomy or partial mastectomy.

Other Reconstructive and Corrective Surgery. The Plan Covers reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

- Performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect;
- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- Otherwise Medically Necessary.

Telemedicine Program. In addition to providing Covered Services via telehealth, the Plan Covers online internet consultations between You and Providers who participate in the telemedicine program for medical conditions that are not an Emergency Condition.

The telemedicine program is the delivery of healthcare services through the use of privacy compliant technology. Telemedicine visits allow You to connect with a doctor 24 hours a day, 365 days per year, including holidays, via a secure two-way video, or telephone for the purposes of diagnosis, consultation and treatment; just as would be provided during a face to face office visit.

Transplants. The Plan Covers only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to kidney, corneal, liver, heart, pancreas and lung transplants; and bone marrow transplants.

All transplants must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that the Plan has specifically approved and designated to perform these procedures.

The Plan Covers the Hospital and medical expenses of the Member-recipient, which includes organ procurement, pre-transplant and post-transplant services.

The Plan Covers pre-transplant (excluding donor search, screening or fees in connection with organ transplant surgery) and post-transplant services required:

- by You when You serve as an organ donor if the recipient is a Member;

- by You when You serve as an organ donor if the recipient is a non-Member only if the recipient does not have other coverage or that other coverage does not cover You acting as a donor; or

- by a non-Member acting as a donor for You, only when such non-Member does not have other coverage or that other coverage does not cover donor expenses.

Post-transplant services for non-Members after the surgical procedure for the donor will be reviewed for Medical Necessity.

The Plan does not Cover: travel expenses, lodging, meals, or other accommodations for You, donors or guests; or routine harvesting and storage of stem cells from newborn cord blood.

SECTION X. Additional Benefits, Equipment and Devices

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

Diabetic Equipment, Supplies and Self-Management Education. The Plan Covers diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the New York Education Law as described below:

A. **Equipment and Supplies.**
The Plan Covers the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other Provider legally authorized to prescribe:

- Acetone reagent strips
- Acetone reagent tablets
- Alcohol or peroxide by the pint
- Alcohol wipes
- All insulin preparations
- Automatic blood lance kit
- Cartridges for the visually impaired
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the pump
- Glucagon for injection to increase blood glucose concentration
- Glucose acetone reagent strips
- Glucose kit
- Glucose monitor with or without special features for visually impaired, control solutions, and strips for home glucose monitor
- Glucose reagent tape
- Glucose test or reagent strips
- Injection aides
- Injector (Busher) Automatic
- Insulin cartridge delivery
- Insulin infusion devices
- Insulin pump
- Lancets
- Oral agents such as glucose tablets and gels
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

Insulin and other diabetic Prescription Drugs, supplies or equipment (collectively referred to in this section as “Diabetic Services”) may be Covered under the Prescription Drug Coverage section of the Booklet and not this section.

B. **Preauthorization.** Preauthorization may be needed for certain Diabetic Services to make sure proper use and guidelines for coverage are followed. When appropriate, ask Your Provider to complete a Preauthorization form. Should You choose to purchase the Diabetic Service without obtaining Preauthorization, You must pay for the cost of the entire Diabetic Service and submit a claim for reimbursement to the Claims Administrator for services that are Covered under this section of the Booklet or to the Prescription Drug Benefit Manager for services that are Covered under the Prescription Drug Coverage section of this Booklet.

For a list of Diabetic Services that require Preauthorization, please visit www.excellusbcbs.com or www.proactrx.com or call the Claims Administrator at the number on Your ID card or the Prescription Drug Benefit Manager at 877-635-9545. The list will be reviewed and updated from time to time. The Plan reserves the right to require Preauthorization for any new Diabetic Service on the market. However, Preauthorization requirements will not be added to a Diabetic Service on the Formulary during a Plan Year unless the requirements are added pursuant to FDA safety concerns. Your Provider may check with the Claims Administrator for Diabetic Services Covered under this section or the Prescription Drug Benefit Manager for Diabetic Services Covered under the Prescription Drug Coverage section of this Booklet to find out which Diabetic Services are Covered.

C. **Other Diabetic Drugs, Supplies and Equipment That Receive FDA Approval.** Preauthorization or step therapy applies to all new Diabetic Services entering the market upon FDA approval, whether or not listed above, until the Plan determines that the new item satisfies the Plan's criteria for safety, efficacy and cost-effectiveness.

D. **Other Changes.** The Plan may add or change Preauthorization or step therapy requirements: on a brand name item when a therapeutically equivalent generic drug, supply or equipment becomes available; or to promote safe utilization of an item based on new clinical guidelines or information related to safety or effectiveness. These changes will be made following notice to affected Members.

E. **Diabetic Drug Utilization, Cost Management**. The Plan conducts various utilization management activities designed to ensure appropriate diabetic Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate diabetic Prescription Drugs in a cost-effective manner.

In addition, as part of the utilization management activities, the Prescription Drug Benefit Manager (or its designee) may receive rebates or other funds ("rebates") directly or indirectly from diabetic Prescription Drug manufacturers, diabetic Prescription Drug distributors or others and may share all or a portion of those rebates with the Plan. Any rebates received by the Plan may be used to offset or reduce administrative fees of the Plan. Rebates may also change or reduce the amount of any Member Copayment or Coinsurance applicable under the diabetic Prescription Drug coverage. Not all diabetic Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the rebate will not be known at the time You purchase the diabetic Prescription Drug, the amount of the rebate applied to Your claim will be based on an estimate. Payment on Your claim and Your Cost-Sharing

will not be adjusted if the later-determined rebate value is higher or lower than the estimate.

F. **Self-Management Education.** Diabetes self-management education is designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. The Plan Covers education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care Provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
- Upon the Referral of Your Physician or other health care Provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

G. **Limitations.**
Diabetic Services will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. The Plan only Covers basic models of glucose monitors and other equipment unless You have special needs relating to poor vision or blindness or as otherwise Medically Necessary.

Durable Medical Equipment. The Plan Covers the rental or purchase of durable medical equipment.

Durable Medical Equipment is equipment which is:
- Designed and intended for repeated use;
- Can normally be rented and reused by successive patients;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Coverage is for standard equipment only. The Plan Covers the cost of repair or replacement for purchased equipment when made necessary by normal wear and tear. The Plan does not Cover the cost of maintenance, repair or replacement covered under warranty or that is the result of misuse or, abuse by You, loss, natural disaster or theft. The Plan will determine whether to rent or purchase such equipment. The Plan does not Cover over-the-counter durable medical equipment.

The Plan does not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment.

Hearing Aids.

A. **Cochlear Implants.** The Plan Covers bone anchored hearing aids (i.e., cochlear implants) when they are Medically Necessary to correct a hearing impairment. Examples of when bone anchored hearing aids are Medically Necessary include the

following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid;
- Other acquired malformations of the middle or external ear canals which preclude the wearing of a conventional air conduction hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

The Plan Covers repair and/or replacement of a bone anchored hearing aid only for malfunctions.

B. **External Hearing Aids.** The Plan does not Cover hearing aids.

Hospice. Hospice Care is available if Your primary attending Physician has certified that You have six (6) months or less to live. The Plan Covers inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. The Plan also Covers five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

The Plan Covers Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. The Plan does not Cover: funeral arrangements; pastoral, financial, or legal counseling; or homemaker, caretaker, or respite care.

Medical Supplies. The Plan Covers disposable medical supplies that are required for the treatment of a disease or injury which is Covered under Booklet. The Plan also Covers maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Booklet. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. Your Physician must order these supplies. The Plan does not Cover over-the-counter medical supplies. The Plan also does not cover supplies that are considered to be purchased primarily for comfort or convenience; delivery and/or handling charges.

See the Diabetic Equipment, Supplies, and Self-Management Education section above for a description of diabetic supply Coverage.

Orthotics. The Plan Covers orthotics, including external braces, foot orthotics and custom-built supports, that are necessary to: support, restore or protect body function; redirect, eliminate or restrict motion of an impaired body part; or relieve or correct a condition caused by an injury, illness, disease or defect. Coverage is for standard equipment only. The Plan Covers replacements: due to a change in Your condition; when required repairs would exceed the cost of a replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. The Plan does not Cover the cost of repairs or replacement that are the result of misuse or abuse by You or result from loss, natural disaster, or theft.

Ostomy Equipment and Supplies. The Plan Covers ostomy equipment and supplies prescribed or recommended by a Health Care Professional.

Prosthetics.

A. **External Prosthetic Devices.** The Plan Covers prosthetic devices that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. The Plan will Cover replacements: due to a change in physiological condition; when required repairs would exceed the cost of a replacement device or parts that need to be replaced; or when there has been an irreparable change in the condition of the device due to normal wear and tear. Your Physician must order the prosthetic device for Your condition before its purchase. Although the Plan requires that a Physician prescribe the device, this does not mean that the Plan will automatically determine You need it. Prosthetic devices do not include, for example: hearing aids; eyeglasses; contact lenses; medical supplies; wigs; or foot orthotics such as arch supports or insoles, regardless of the Medical Necessity of those items.

   The Plan does not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

   The Plan Covers external breast prostheses following a mastectomy.

   Coverage is for standard equipment only.

B. **Internal Prosthetic Devices.** The Plan Covers surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

   Coverage also includes repair and replacement due to normal growth or normal wear and tear.

SECTION XI. Inpatient Services

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

Hospital Services. The Plan Covers inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits section of this Booklet apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days for the same or related causes.

Observation Services. The Plan Covers observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

Inpatient Medical Services. The Plan Covers medical visits by a Health Care Professional on any day of inpatient care Covered under this Booklet.

The Health Care Professional's services must be documented in the Facility records. The Plan will cover only one (1) visit per day per Health Care Professional.

Inpatient Stay for Maternity Care. The Plan Covers inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery,

regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. The Plan will also Cover any additional days of such care that are determined to be Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, the Plan will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Coverage of this home care visit shall be in addition to home health care visits under this Booklet and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Booklet that apply to home care benefits.

The Plan also Covers the inpatient use of pasteurized donor human milk, which may include fortifiers as Medically Necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

Inpatient Stay for Mastectomy Care. The Plan Covers inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

Autologous Blood Banking Services. The Plan Covers autologous blood banking services only when they are being provided in connection with a scheduled, Covered surgical procedure for the treatment of a disease or injury. In such instances, the Plan Covers storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

Rehabilitation Services. The Plan Covers inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy.

Skilled Nursing Facility. The Plan Covers services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in “Hospital Services” above. Custodial, convalescent or domiciliary care is not Covered (see the Exclusions and Limitations section of this Booklet).

End of Life Care. If You are diagnosed with advanced cancer and You have fewer than 60 days to live, the Plan will Cover Acute care provided in a licensed Article 28 Facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility’s medical director must agree that Your care will be appropriately provided at the Facility. If the Plan disagrees with Your admission to the Facility, the Plan has the right to initiate an expedited external appeal to an External Appeal Agent. The Plan will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Booklet until the External Appeal Agent renders a decision in favor of the Plan.

Limitations/Terms of Coverage.

- When You are receiving inpatient care in a Facility, the Plan will not Cover additional

charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.

- The Plan does not Cover radio, telephone or television expenses, or beauty or barber services.
- The Plan does not Cover any charges incurred after the day You are advised it is no longer Medically Necessary for You to receive inpatient care, unless the Plan's denial is overturned by an External Appeal Agent.

SECTION XII. Mental Health Care and Substance Use Services

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008, as may be amended from time to time.

Mental Health Care Services. The Plan Covers the following mental health care services to treat a mental health condition. For purposes of this benefit, "mental health condition" means any mental health disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

A. **Inpatient Services.** The Plan Covers inpatient mental health care services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical and surgical coverage provided under this Booklet. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:

- A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
- A state or local government run psychiatric inpatient Facility;
- A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
- A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health; and, in other states, to similarly licensed or certified Facilities. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Plan.

The Plan also Covers inpatient mental health care services relating to the diagnosis and treatment of mental health conditions received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03 and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to New York Mental Hygiene Law Article 30; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment. In the absence of a licensed or certified Facility that provides the same level of treatment, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Plan.

B. **Outpatient Services.** The Plan Covers outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental health conditions. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to New York Mental Hygiene Law Article 31 or are operated by the New York State Office of Mental Health and crisis stabilization centers licensed pursuant to New York Mental Hygiene Law section 36.01

and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three (3) years of additional experience in psychotherapy; a licensed nurse practitioner; a licensed mental health counselor; a licensed marriage and family therapist; or a professional corporation or a university faculty practice corporation thereof. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by the Plan. Outpatient services also include nutritional counseling to treat a mental health condition.

C. **Autism Spectrum Disorder.** The Plan Covers the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined to be Medically Necessary for the screening, diagnosis, or treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

- **Screening and Diagnosis.** The Plan Covers assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

- **Assistive Communication Devices.** The Plan Covers a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, the Plan Covers the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. The Plan will only Cover devices that generally are not useful to a person in the absence of a communication impairment. The Plan does not Cover items, such as, but not limited to, laptop, desktop or tablet computers. The Plan Covers software and/or applications that enable a laptop, desktop or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. The Plan will determine whether the device should be purchased or rented.

  The Plan Covers repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. The Plan does not Cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft; however, the Plan Covers one (1) repair or replacement per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to Your current functional level. The Plan does not Cover delivery or service charges or routine maintenance.

- **Behavioral Health Treatment.** The Plan Covers counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. Coverage will be provided when rendered by a licensed Provider. Applied behavior analysis is Covered when provided by a licensed or certified applied behavior analysis Health Care

Professional. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

- **Psychiatric and Psychological Care.** The Plan Covers direct or consultative services provided by a psychiatrist, psychologist or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.

- **Therapeutic Care.** The Plan Covers therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Plan. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Booklet.

- **Pharmacy Care.** The Plan Covers Prescription Drugs to treat autism spectrum disorder that are prescribed by a Provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Booklet and described in the Prescription Drug Coverage section of this Booklet.

- **Limitations.** The Plan does not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan New York Public Health Law Section 2545, an individualized education plan New York Education Law Article 89, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this Booklet for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable Copayment, Deductible or Coinsurance provisions under this Booklet for similar "mental health condition" services. For example, any Copayment, Deductible or Coinsurance that applies to outpatient visits for "mental health conditions" will also apply to physical therapy services Covered under this benefit; and any Copayment, Deductible or Coinsurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. See the Schedule of Benefits section of this Booklet for the Cost-Sharing requirements that apply to "mental health conditions" or Prescription Drugs.

Substance Use Services. The Plan Covers the following substance use services to treat a substance use disorder. For purposes of this benefit, "substance use disorder" means any substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

A. **Inpatient Services.** The Plan Covers inpatient substance use services relating to the diagnosis and treatment of substance use disorders. This includes Coverage for detoxification and rehabilitation services for substance use disorders. Inpatient substance use services are limited to Facilities in New York State which are licensed, certified or otherwise authorized by the Office of Addiction Services and Supports ("OASAS"); and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by the Plan as alcoholism, substance abuse or chemical dependence treatment programs.

The Plan also Covers inpatient substance use services relating to the diagnosis and treatment of substance use disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities that are licensed, certified or otherwise authorized by OASAS; and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by the Plan as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

B. **Outpatient Services.** The Plan Covers outpatient substance use services relating to the diagnosis and treatment of substance use disorders, including but not limited to partial hospitalization program services, intensive outpatient program services, opioid treatment programs including peer support services, counseling, and medication-assisted treatment. Such Coverage is limited to Facilities in New York State that are licensed, certified or otherwise authorized by OASAS to provide outpatient substance use disorder services and crisis stabilization centers licensed pursuant to New York Mental Hygiene Law section 36.01 and, in other states, to those that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

C. **Additional Family Counseling.** The Plan also Covers outpatient visits for family counseling. A family member will be deemed to be covered, for the purpose of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from substance use disorder; and 2) is covered under the same Plan option (and enrolled in the same family coverage) that covers the person receiving, or in need of, treatment for substance use disorder. The Plan's payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

SECTION XIII. Prescription Drug Coverage

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

Covered Prescription Drugs. The Plan Covers Medically Necessary Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines;
- On the Formulary; and
- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders include but are not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies. Multiple food allergies include, but are not limited to: immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.
- Modified solid food products that are low in protein, contain modified protein, or are amino acid based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit, including in vitro fertilization, in the Outpatient and Professional Services section of this Booklet.
- Off-label cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson

Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.

- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs, including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a Provider.
- Preventive Prescription Drugs, including over-the-counter drugs for which there is a written order, provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") or that have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF").
- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification, maintenance and overdose reversal.
- Contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. You may request coverage for an alternative version of a contraceptive drug, device and other product if the Covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by Your attending Health Care Provider.

You may request a paper copy of the Formulary. The Formulary is also available at www.proactrx.com. You may inquire if a specific drug is Covered under this Booklet by contacting the Prescription Drug Benefit Manager at 877-635-9545.

Refills. The Plan Covers Refills of Prescription Drugs only when dispensed at a retail, mail order or Designated Pharmacy as ordered by an authorized Provider and only after ¾ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one (1) year from the original prescription date. For prescription eye drop medication, the Plan allows for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits section of this Booklet.

Benefit and Payment Information.

A. **Cost-Sharing Expenses.** You are responsible for paying the costs outlined in the Schedule of Benefits section of this Booklet when Covered Prescription Drugs are obtained from a retail, mail order or Designated Pharmacy.

Depending on the Plan option You are enrolled in, You have either a two (2) tier plan design or a three (3) tier plan design.

- If You have a two (2) tier plan design, it means that You will have lower out-of-pocket expenses for tier one drugs and higher out-of-pocket expenses for tier two drugs.

- If You have a three (3) tier plan design, it means that Your out-of-pocket expenses will generally be lowest for Prescription Drugs on tier one and highest for Prescription Drugs on tier three. Your out-of-pocket expense for Prescription Drugs on tier two will generally be more than for tier one but less than tier three.

You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug and the contracted rates (the Prescription Drug Cost) will not be available to You.

B. **Participating Pharmacies.** For Prescription Drugs purchased at a retail, mail order or designated Participating Pharmacy, You are responsible for paying the lower of:

- The applicable Cost-Sharing; or
- The Prescription Drug Cost for that Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

In the event that a Participating Pharmacy is unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with the Plan's prior approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. The Plan will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required Participating Pharmacy Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact the Prescription Drug Benefit Manager at 877-635-9545 or visit www.proactrx.com to request approval.

C. **Non-Participating Pharmacies.** The Plan will not pay for any Prescription Drugs that You purchase at a Non-Participating retail or mail order Pharmacy other than as described above.

D. **Designated Pharmacies.** If You require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, the Plan may direct You to a Designated Pharmacy with whom the Plan has an arrangement with to provide those Prescription Drugs. However, the Plan will provide benefits that apply to Prescription Drugs dispensed by a designated pharmacy to Prescription Drugs that are purchased from a retail pharmacy when that retail pharmacy is a Participating Pharmacy and agrees to the same reimbursement amount as the designated pharmacy.

Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a Provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports.

If You are directed to a designated pharmacy and You choose not to obtain Your Prescription Drug from a designated pharmacy, You will not have coverage for that Prescription Drug.

Following are the therapeutic classes of Prescription Drugs or conditions that are included in this program:

- Acromegaly;
- Age related macular degeneration;
- AIDS wasting syndrome;
- Allergic Rhinitis;
- Amyloid cardiomyopathy;
- Anemia, neutropenia, thrombocytopenia;
- Ankylosing Spondylitis;
- Atopic Dermatitis;
- Cancer;
- Cardiovascular;
- Chorea associated with Huntington Disease;
- Chronic Granulomatous Disease;
- Crohn's disease;
- Cystic fibrosis;
- Duchenne's Muscular Dystrophy;
- Enzyme deficiencies;
- Gaucher's disease;
- Giant Cell Arteritis;
- Growth hormone related disorders;
- Hemophilia;
- Hepatitis B;
- Hepatitis C;
- Hereditary Angioedema;
- Heterozygous and Homozygous Familial Hypercholesterolemia;
- Hidradenitis Suppurativa;
- HIV/AIDS;
- Hormonal disorders such as endometriosis, precocious puberty, Cushing's Syndrome;
- Hyperkalemia;
- Idiopathic Pulmonary Fibrosis;
- Immune deficiency disorders;
- Infantile Hemangioma;
- Infertility;
- Inherited disorders of metabolism;
- Iron overload;
- Iron toxicity;
- Juvenile idiopathic arthritis;
- Lipodystrophy;
- Lupus;
- Migraine;
- Multiple sclerosis;
- Narcolepsy;
- Nephropathic Cystinosis;
- Neurogenic orthostatic hypotension;
- Neurologic disorders such as infantile spasms;
- Neurotrophic keratitis;
- Non 24-Hour Sleep Wake Disorder;

- Non-radiographic Axial Spondylitis;
- Osteoarthritis;
- Osteoporosis;
- Parkinson's disease;
- Parkinson's Induced Psychosis;
- Peanut Allergy;
- Peripheral stem cell collection;
- Primary Biliary Cholangitis;
- Psoriasis;
- Psoriatic arthritis;
- Pulmonary hypertension;
- Respiratory conditions such as asthma, eosinophilic granulomatosis with polyangiitis;
- Rheumatoid arthritis;
- RSV prevention;
- Seizure disorders such as infantile spasm and refractory complex partial seizures, Lennox-Gastaut syndrome, Dravet syndrome;
- Short bowel syndrome;
- Sickle Cell Anemia;
- Tardive Dyskinesia;
- Thrombocytopenia;
- Toxoplasmosis;
- Transplant;
- Ulcerative colitis;
- Vasoactive intestinal peptide tumors.

E. **Mail Order.** Certain Prescription Drugs may be ordered through the mail order pharmacy. You are responsible for paying the lower of:

- The applicable Cost-Sharing; or
- The Prescription Drug Cost for that Prescription Drug.

(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three (3) Refills). You will be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number of days' supply written on the Prescription Order or Refill.

Prescription Drugs purchased through mail order will be delivered directly to Your home or office.

The Plan will provide benefits that apply to Prescription Drugs dispensed by a mail order pharmacy to Prescription Drugs that are purchased from a retail pharmacy when that retail pharmacy is a Participating Pharmacy and agrees to the same reimbursement amount as a participating mail order pharmacy.

You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting www.proactrx.com or by calling Your Prescription Drug

Benefit Manager at 877-635-9545 .

F. **Formulary Changes.** The Formulary is subject to periodic review and modification. However, a Prescription Drug will not be removed from the Formulary during the Plan Year, except when the FDA determines that such Prescription Drug should be removed from the market. Before a Prescription Drug is removed from the Formulary at the beginning of the upcoming Plan Year, the Plan will provide at least 90 days' notice prior to the start of the Plan Year. The Plan will also post such notice at www.proactrx.com.

The Plan will not add utilization management restrictions (e.g., step therapy or Preauthorization requirements) to an existing Prescription Drug on the Formulary during a Plan Year unless the requirements are added pursuant to FDA safety concerns.

G. **Tier Status.** A Prescription Drug will not be moved to a tier with a higher Cost-Sharing during the Plan Year, except a Brand-Name Drug may be moved to a tier with higher Cost-Sharing if an AB-rated generic equivalent or interchangeable biological product for that Prescription Drug is added to the Formulary at the same time. Additionally, a Prescription Drug may be moved to a tier with a higher Copayment during the Plan Year, although the change will not apply to You if You are already taking the Prescription Drug or You have been diagnosed or presented with a condition on or prior to the start of the Plan Year which is treated by such Prescription Drug or for which the Prescription Drug is or would be part of Your treatment regimen.

Before a Prescription Drug is moved to a different tier, the Plan will provide at least 90 days' notice prior to the start of the Plan Year. The notice will also be posted at http://www.healthconsortium.net/empl-retiree. If a Prescription Drug is moved to a different tier during the Plan Year for one of the reasons described above, the Plan will provide at least 30 days' notice before the change is effective. You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. You may access the most up to date tier status at http://www.healthconsortium.net/empl-retiree or by calling the Prescription Drug Benefit Manager at 877-635-9545.

H. **Formulary Exception Process.** If a Prescription Drug is not on the Formulary, You, Your designee or Your prescribing Health Care Professional may request a Formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. If coverage is denied under the standard or expedited Formulary exception process, You are entitled to an external appeal as outlined in the External Appeal section of this Booklet. Visit www.proactrx.com or call the Prescription Drug Benefit Manager at 877-635-9545 to find out more about this process.

- **Standard Review of a Formulary Exception.** The Plan will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone no later than 72 hours after it receives Your request. The Plan will notify You in writing within three (3) business days of receipt of Your request. If Your request is approved, the Plan will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

- **Expedited Review of a Formulary Exception.** If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain

maximum function or if You are undergoing a current course of treatment using a non-Formulary Prescription Drug, You may request an expedited review of a Formulary exception. The request should include a statement from Your prescribing Health Care Professional that harm could reasonably come to You if the requested drug is not provided within the timeframes for the standard Formulary exception process. The Plan will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone no later than 24 hours after Our receipt of Your request. The Plan will notify You in writing within three (3) business days of receipt of Your request. If Your request is approved, the Plan will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-Formulary Prescription Drug.

I. **Supply Limits.** Except for contraceptive drugs, devices, or products, the Plan will pay for no more than a 90-day supply of a Prescription Drug purchased at a retail pharmacy or designated pharmacy. You are responsible for one (1) Cost-Sharing amount for a 30-day supply and three (3) Cost-Sharing amounts for a 90-day supply. The Cost-Sharing amounts applicable to the Plan option You are enrolled in are identified in the Prescription Drug Coverage Schedule of Benefits.

You may have the entire supply (of up to 12 months) of the contraceptive drug, device or product dispensed at the same time. Contraceptive drugs, devices or products are not subject to Cost-Sharing when provided by a Participating Pharmacy.

Benefits will be provided for Prescription Drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for the Cost-Sharing amounts identified on the Prescription Drug Coverage Schedule of Benefits for the applicable Plan option You are enrolled in.

Some Prescription Drugs may be subject to quantity limits based on criteria that the Plan has developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing the Prescription Drug Benefit Manager's website at www.proactrx.com or by calling 877-635-9545. If the Plan denies a request to Cover an amount that exceeds the quantity level, You are entitled to an Appeal pursuant to the Utilization Review and External Appeal sections of this Booklet.

J. **Initial Limited Supply of Prescription Opioid Drugs.** If You receive an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for Acute pain, and You have a Copayment, Your Copayment will be prorated. If You receive an additional supply of the Prescription Drug within the 30-day period in which You received the seven (7) day supply, Your Copayment for the remainder of the 30-day supply will also be prorated. In no event will the prorated Copayment(s) total more than Your Copayment for a 30-day supply.

K. **Cost-Sharing for Orally-Administered Anti-Cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is at least as favorable to You as the Cost-

Sharing amount, if any, that applies to intravenous or injected anticancer medications Covered under the Outpatient and Professional Services section of this Booklet.

L. **Split Fill Dispensing Program.** The split fill dispensing program is designed to prevent wasted Prescription Drugs if Your Prescription Drug or dose changes. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and reactions. You will initially get up to a 15-day supply of Your Prescription Order for certain drugs filled at a Designated Pharmacy instead of the full Prescription Order. You initially pay a lesser Cost-Sharing based on what is dispensed. The therapeutic classes of Prescription Drugs that are included in this program are: Oncology, orphan drugs, inflammatory agents, and Multiple Sclerosis. This program applies for the first 60 days when You start a new Prescription Drug. This program will not apply upon You or Your Provider's request. You or Your Provider can opt out by visiting www.proactrx.com or by calling the Prescription Drug Benefit Manager at 877-635-9545 .

Medical Management. This Booklet includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before it can be determined that the Prescription Drug is Medically Necessary.

A. **Preauthorization.** Depending on the Plan option You are enrolled in, Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, ask Your Provider to complete a Preauthorization form. Preauthorization is not required for Covered medications to treat substance use disorder, including opioid overdose reversal medications prescribed or dispensed to You.

The Prescription Drug Coverage Schedule of Benefits section of this Booklet will include whether or not Preauthorization applies. If Preauthorization applies, for a list of Prescription Drugs that need Preauthorization, please visit www.proactrx.com or call the Prescription Drug Benefit Manager at 877-635-9545. The list will be reviewed and updated from time to time. The Plan also reserves the right to require Preauthorization for any new Prescription Drug on the market. However, the Plan will not add Preauthorization requirements to a Prescription Drug on the Formulary during a Plan Year unless the requirements are added pursuant to FDA safety concerns. Your Provider may check with the Prescription Drug Benefit Manager to find out which Prescription Drugs are Covered.

B. **Step Therapy**. Depending on the Plan option You are enrolled in, step therapy may apply. The Prescription Drug Coverage Schedule of Benefits section of this Booklet will include whether or not step therapy applies.

Step therapy is a process in which You may need to use one (1) or more types of Prescription Drugs before the Plan will Cover another as Medically Necessary. A "step therapy protocol" means the Plan's policy, protocol or program that establishes the sequence in which Prescription Drugs are approved for Your medical condition. When establishing a step therapy protocol, the Plan will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. The Plan will check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You

get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list. If a step therapy protocol is applicable to Your request for coverage of a Prescription Drug, You, Your designee, or Your Health Care Professional can request a step therapy override determination as outlined in the Utilization Review section of this Booklet. The Plan will not add step therapy requirements to a Prescription Drug on the Formulary during a Plan Year unless the requirements are added pursuant to FDA safety concerns.

Limitations/Terms of Coverage.

A. The Plan reserves the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

B. If the Plan determines that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, the Plan may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You do not make a selection within 31 days of the date the Plan notifies You, the Plan will select a single Participating Pharmacy for You.

C. Compounded Prescription Drugs will be Covered only when the primary ingredient is a Covered legend Prescription Drug, they are not essentially the same as a Prescription Drug from a manufacturer and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs over $150 require Your Provider to obtain Preauthorization.

D. Various specific and/or generalized “use management” protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.

E. Injectable drugs (other than self-administered injectable drugs) and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of this Booklet.

F. The Plan does not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician’s office are Covered under the Outpatient and Professional Services section of this Booklet.

G. The Plan does not Cover drugs that do not by law require a prescription, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an “A” or “B” rating from USPSTF or as otherwise provided in this Booklet. The Plan does not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same

name/chemical entity as their prescription counterparts. The Plan does not Cover repackaged products such as therapeutic kits or convenience packs that contain a Covered Prescription Drug unless the Prescription Drug is only available as part of a therapeutic kit or convenience pack. Therapeutic kits or convenience packs contain one or more Prescription Drug(s) and may be packaged with over-the-counter items, such as gloves, finger cots, hygienic wipes or topical emollients.

H. The Plan does not Cover Prescription Drugs to replace those that may have been lost or stolen.

I. The Plan does not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.

J. The Plan reserves the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of this Booklet.

K. A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

General Conditions.

A. You must provide the pharmacy with identifying information that can be verified by the Prescription Drug Benefit Manager during regular business hours. You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.

B. **Drug Utilization, Cost Management and Rebates.** The Plan conducts various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner.

In addition, as part of the utilization management activities, the Prescription Drug Benefit Manager (or its designee) may receive rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others and may share all or a portion of those rebates with the Plan. Any rebates received by the Plan may be used to offset or reduce administrative fees of the Plan. Rebates may also change or reduce the amount of any Member Copayment or Coinsurance applicable under the Prescription Drug coverage. Not all Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the rebate will not be known at the time You purchase the Prescription Drug, the amount of the rebate applied to Your claim will be based on an estimate. Payment on Your claim and Your Cost-Sharing will not be adjusted if the later-determined rebate value is higher or lower than the estimate.

Definitions. Terms used in this section are defined as follows. (Other defined terms can be found in the Definitions section of this Booklet).

A. **Designated Pharmacy:** A pharmacy that has entered into an agreement with the Prescription Drug Benefit Manager or with an organization contracting on behalf of the Prescription Drug Benefit Manager, to provide specific Prescription Drugs, including but not limited to, specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.

B. **Formulary:** The list that identifies those Prescription Drugs for which coverage may be available under this Booklet. To determine which tier a particular Prescription Drug has been assigned visit www.proactrx.com or call the Prescription Drug Benefit Manager at 877-635-9545.

C. **Generic Drug:** A Prescription Drug that 1) is chemically equivalent to a Brand-Name Drug; or 2) is identified as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as "generic" by the manufacturer, pharmacy, or Your Physician may not be classified as a Generic Drug by the Plan.

D. **Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with the Prescription Drug Benefit Manager to provide Prescription Drugs to Members. The Plan will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.

E. **Participating Pharmacy:** A pharmacy that has:

- Entered into an agreement with the Prescription Drug Benefit Manager or its designee to provide Prescription Drugs to Members;
- Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
- Been designated by the Plan as a Participating Pharmacy.

A Participating Pharmacy can be either a retail or mail-order pharmacy.

F. **Preferred Brand-Drug:** A Prescription Drug that: 1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or 2) is identify by the Plan as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as "brand name" by the manufacturer, pharmacy, or Your Physician may not be classified as a Brand-Name Drug by the Plan.

G. **Prescription Drug:** A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is on the Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

H. **Prescription Drug Cost:** The amount, including a dispensing fee and any sales tax, the Plan have agreed to pay Participating Pharmacies for a Covered Prescription Drug dispensed at a Participating Pharmacy.

I. **Prescription Order or Refill:** The directive to dispense a Prescription Drug issued by a duly licensed Health Care Professional who is acting within the scope of his or her practice.

J. **Usual and Customary Charge:** The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by New York Education Law Section 6826-a.

SECTION XIV. Exclusions and Limitations

No coverage is available under this Booklet for the following:

Acupuncture.
The Plan does not Cover acupuncture.

Convalescent and Custodial Care.
The Plan does not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

Conversion Therapy.
The Plan does not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

Cosmetic Services.
The Plan does not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. The Plan also Covers services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Booklet. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Booklet unless medical information is submitted.

Dental Services. The Plan does not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services section of this Booklet.

Experimental or Investigational Treatment.
The Plan does not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, the Plan will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Booklet, when the denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, the Plan will not

Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Booklet for non-investigational treatments. See the Utilization Review and External Appeal sections of this Booklet for a further explanation of Your Appeal rights.

Felony Participation.
The Plan does not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

Foot Care.
The Plan does not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, the Plan does Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

Government Facility.
The Plan does not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

Hearing Services.
The Plan does not Cover the routine hearing examinations, hearing therapy or hearing aids.

Medically Necessary.
In general, the Plan will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that is determined to be not Medically Necessary. If an External Appeal Agent overturns the Plan's denial, however, the Plan will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied.

Medicare or Other Governmental Program.
The Plan does not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When You are eligible for Medicare, the Plan will reduce its benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare premium. Benefits for Covered Services will not be reduced if the Plan is required by federal law to pay first or if You are not eligible for premium-free Medicare Part A.

This exclusion will not apply to You if one of the following applies:

A. **Eligibility for Medicare by Reason of Age.** You are entitled to benefits under Medicare by reason of Your age, and the following conditions are met:
   - The Plan Participant is in "current employment status" (working actively and not retired) with the Participating Employer; and
   - The Plan is required by law to pay the benefits described in this Booklet before Medicare.

B. **Eligibility for Medicare by Reason of Disability Other than End-Stage Renal Disease.** You are entitled to benefits under Medicare by reason of disability (other than end-stage renal disease), and the following conditions are met:

- The Plan Participant is in "current employment status" (working actively and not retired) with the group contract holder; and
- The Plan is required by law to pay the benefits described in this Booklet before Medicare.

C. **Eligibility for Medicare by Reason of End-Stage Renal Disease.** You are entitled to benefits under Medicare by reason of end-stage renal disease, and there is a waiting period before Medicare coverage becomes effective. The Plan will not reduce its benefits, and it will provide benefits before Medicare pays, during the waiting period. The Plan will also provide benefits before Medicare pays during the coordination period with Medicare. After the coordination period, Medicare will pay its benefits before the Plan provides benefits described in this Booklet.

Military Service.
The Plan does not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

No-Fault Automobile Insurance.
The Plan does not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

Nutritional Therapy.
The Plan does not Cover nutritional therapy, unless it is with respect to diabetes self-management education or otherwise required by law. The Plan does not Cover any materials, supplies, dietary supplements or commercial weight loss programs.

Private Duty Nursing.
The Plan does not Cover private duty nursing.

Reproductive Services.
The Plan does not Cover any of the following reproductive services: gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), costs associated with an ovum or sperm donor (including the donor's medical expenses), cryopreservation and storage of embryos (except in connection with in-vitro fertilization), ovulation predictor kits, reversal of tubal ligations, reversal of vasectomies, costs for services related to surrogate motherhood (not otherwise covered under the Plan), or cloning and related costs.

Services Not Listed.
The Plan does not Cover services that are not listed in this Booklet as being Covered.

Services Provided by a Family Member.
The Plan does not Cover services performed by a Member's immediate family member. "Immediate family member" means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

Services Separately Billed by Hospital Employees.
The Plan does not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Services with No Charge.
The Plan does not Cover services for which no charge is normally made.

Vision Services.
The Plan does not Cover routine eye examinations, routine eyewear, vision therapy or the fitting of eyeglasses or contact lenses.

Wigs, Hair Prosthetics or Hair Implants.
The Plan does not Cover wigs, hair prosthetics or hair implants.

Workers' Compensation.
The Plan does not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

SECTION XV. Claim Determinations

Claims.
A claim is a request that benefits or services be provided or paid according to the terms of this Booklet. When You receive services from a Participating Provider or Participating Pharmacy, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with the Claims Administrator. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with the Claims Administrator. See the Coordination of Benefits section of this Booklet for information on how the Plan coordinates benefit payments when You also have group health coverage with another plan.

Notice of Claim.
Claims for services must include all information designated by the Plan as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from the Claims Administrator by calling the number on Your ID card or the Prescription Drug Benefit Manager at 877-635-9545. Completed medical claim forms should be sent to the Claims Administrator's address on Your ID card. Completed Prescription Drug claims should be sent to the Prescription Drug Benefit Manager at the following address: ProAct, Inc., 1230 US Hwy 11, Gouverneur, NY 13642. You may also submit a claim to the Claims Administrator or Prescription Drug Benefit Manager, as applicable, electronically by visiting its website.

Timeframe for Filing Claims.
Claims for services must be submitted to the Claims Reviewer, for payment within 12 months after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 12-month period, You must submit it as soon as reasonably possible.

Claims for Prohibited Referrals.
The Plan is not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by New York Public Health Law Section 238-a(1).

Claim Determinations.
The claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, the claim determination procedure applies to contractual benefit denials. If You disagree with the claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Booklet.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Booklet.

A. **Pre-Service Claim Determinations.**

- A pre-service claim is a request that a service or treatment be approved before it has been received. If the Claims Reviewer has all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination), it will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

  If the Claims Reviewer needs additional information, it will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If the Claims Reviewer receives the information within 45 days, it will make a determination and provide notice to You (or Your designee) in writing, within 15 days of receipt of the information. If all necessary information is not received within 45 days, the Claims Reviewer will make a determination within 15 calendar days of the end of the 45-day period.

- **Urgent Pre-Service Reviews.** With respect to urgent pre-service requests, if the Claims Reviewer has all information necessary to make a determination, it will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If the Claims Reviewer needs additional information, it will request it within 24 hours. You will then have 48 hours to submit the information. The Claims Reviewer will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

B. **Post-Service Claim Determinations.**
A post-service claim is a request for a service or treatment that You have already received. If the Claims Reviewer has all information necessary to make a determination regarding a post-service claim, it will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim if the Claims Reviewer denies the claim in whole or in part. If the Claims Reviewer needs additional information, it will request it within 30 calendar days. You will then have 45 calendar days to provide the information. The Claims Reviewer will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of receipt of the information or the end of the 45-day period if the claim is denied, in whole or in part.

Payment of Claims.
Where the Plan's obligation to pay a claim is reasonably clear, the Claims Reviewer will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If the Claims Reviewer requests additional information, the Plan will pay the claim within 15 days of the Claims Reviewer's determination that payment is due but no later than 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION XVI. Grievance Procedures

Grievances.
The Plan's Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determinations. For example, it applies to contractual benefit denials or issues or concerns You have regarding administrative policies or access to Providers.

Filing a Grievance.
You can contact the Claims Reviewer by phone at the number on Your ID card, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. The Claims Reviewer may require that You sign a written acknowledgement of Your oral Grievance, prepared by it based on Your oral Grievance. You or Your designee have up to 180 calendar days from when You received the decision You are asking the Claims Reviewer to review to file the Grievance.

When the Claims Reviewer receives Your Grievance, it will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

The Claims Review keeps all requests and discussions confidential and the Plan nor the Claims Reviewer will take no discriminatory action because of Your issue. The Plan has a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

You may ask that the Claims Reviewer send You electronic notification of a Grievance or Grievance Appeal determination instead of notice in writing or by telephone. You must tell the Claims Reviewer in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card or visit the Claims Reviewer's website. You can opt out of electronic notifications at any time.

A. **Grievance Determination.**
Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. The the Claims Reviewer will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already	In writing, within 30 calendar days of receipt of Your Grievance.

been provided.)

All Other Grievances: (that are not in relation to a claim or request for a service or treatment.)	In writing, within 30 calendar days of receipt of Your Grievance.

B. **Second-Level Grievance (Appeal).**
If You are not satisfied with the resolution of Your first level Grievance, You or Your designee may file a second level Grievance (appeal) in writing to the following:

Greater Tompkins County Municipal Health Insurance Consortium (GTCMHIC)
Executive Director
Appeals Committee
P.O. Box 7
Ithaca, NY 14851

You have up to 120 calendar days from receipt of the first-level Grievance determination to file a second-level Grievance (appeal).

When the GTCMHIC Executive Director receives Your second-level grievance (appeal), it will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your second-level Grievance (appeal) and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the first-level Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. The GTCMHIC Executive Director will decide the second-level Grievance (appeal) and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:	The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your second-level Grievance (appeal).
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	15 calendar days of receipt of Your second-level Grievance (appeal).
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	30 calendar days of receipt of Your second-level Grievance (appeal).
All Other Grievances: (that are not in relation to a claim or request for service or treatment.)	30 calendar days of receipt of Your second level Grievance (appeal).

C. **Assistance.**
If You remain dissatisfied with the GTCMHC Appeals Committee's second-level Grievance determination, or at any other time You are dissatisfied, You may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

If You need assistance filing a first-level or second-level Grievance, You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XVII. Utilization Review

Utilization Review.
The Plan reviews health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the Claims Reviewer at the number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) with respect to mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. The Claims Reviewer does not compensate employees or provide financial incentives to reviewers for determining that services are not Medically Necessary.

The Claims Reviewer has developed guidelines and protocols to assist in this process. The Plan will use evidence-based and peer reviewed clinical review criteria that are appropriate to the age of the patient and designated by OASAS for substance use disorder treatment or approved for use by OMH for mental health treatment. Specific guidelines and protocols are available for Your review upon request. For more information, call the Claims Reviewer at number on Your ID card or visit the Claims Reviewer's website.

You may ask that the Claims Reviewer send You electronic notification of a Utilization Review determination instead of notice in writing or by telephone. You must tell the Claims Reviewer in advance if You want to receive electronic notifications. To opt into electronic notifications, call the Claims Reviewer’s number on Your ID card or visit the Claims Reviewer’s website. You can opt out of electronic notifications at any time.

A. **Preauthorization Reviews.**

- **Non-Urgent Preauthorization Reviews.** If the Claims Reviewer has all the information necessary to make a determination regarding a Preauthorization review, it will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

  If the Claims Reviewer needs additional information, it will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If the Claims Reviewer receives the requested information within 45 days, it will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the information. If all necessary information is not received within 45 days, the Claims Reviewer will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45-day period.

- **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if the Claims Reviewer has all information necessary to make a determination, it will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If the Claims Reviewer needs additional information, it will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. The Claims Reviewer will make a determination and provide notice to You (or Your designee) and Your Provider by telephone and in writing within 48 hours of the earlier of receipt of the information or the end of the 48 hour period.

- **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, the Claims Reviewer will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

- **Crisis Stabilization Centers.** Coverage for services provided at participating crisis stabilization centers licensed under New York Mental Hygiene Law section 36.01 is not subject to Preauthorization. The Claims Reviewer may review the treatment provided at crisis stabilization centers retrospectively to determine whether it is Medically Necessary and it will use clinical review tools designated by OASAS or approved by OMH. If any treatment at a participating crisis stabilization center is denied as not Medically Necessary, You are only responsible for the Participating Provider Cost-Sharing that would otherwise apply to Your treatment

B. **Concurrent Reviews.**

- **Non-Urgent Concurrent Reviews**. Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If the Claims Reviewer needs additional information, it will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. The Claims Reviewer will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the information or, if the Claims Reviewer does not receive the information, within the earlier of one (1) business day of the receipt of part of the requested information or 15 calendar days of the end of the 45-day period.

- **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, the Claims Reviewer will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and the Claims Reviewer has all the information necessary to make a determination, the Claims Reviewer will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or one (1) business day of receipt of the request. If the Claims Reviewer needs additional information, they will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. The Claims Reviewer will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

- **Home Health Care Reviews.** After receiving a request for coverage of home care services following an inpatient Hospital admission, the Claims Administrator will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, the Claims Administrator will make a determination and provide notice to You (or Your designee) and Your Provider within 72 hours of receipt of the necessary information. When a request is received for home care services, and all necessary information, prior to Your discharge from an inpatient hospital admission, the Plan will not deny coverage for home care services while a determination on the request is pending.

- **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, the Claims Administrator will make a determination within 24 hours of receipt of the request and will provide coverage for the inpatient substance use disorder treatment while the determination is pending.

- **Inpatient Mental Health Treatment for Members under 18 at Participating Hospitals Licensed by the Office of Mental Health (OMH).** Coverage for inpatient mental health treatment at a participating OMH-licensed Hospital is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 14 days of the inpatient admission if the OMH-licensed Hospital notifies the Claims Administrator of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 14 days of the inpatient admission, the Claims Administrator may review the entire stay to determine whether it is Medically Necessary, and will use clinical review tools approved by OMH. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the Participating Provider Cost-Sharing that would otherwise apply to Your inpatient admission.

- **Inpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for inpatient substance use disorder treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 28 days of the inpatient admission if the OASAS-certified Facility notifies the Claims Administrator of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 28 days of the inpatient admission, the Claims Administrator may review the entire stay to determine whether it is Medically Necessary and will use clinical review tools

designated by OASAS. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the Participating Provider Cost-Sharing that would otherwise apply to Your inpatient admission.

- **Outpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first four (4) weeks of continuous treatment, not to exceed 28 visits, if the OASAS-certified Facility notifies the Claims Administrator of both the start of treatment and the initial treatment plan within two (2) business days. After the first four (4) weeks of continuous treatment, not to exceed 28 visits, the Claims Administrator may review the entire outpatient treatment to determine whether it is Medically Necessary and will use clinical review tools designated by OASAS. If any portion of the outpatient treatment is denied as not Medically Necessary, You are only responsible for the Participating Provider Cost-Sharing that would otherwise apply to Your outpatient treatment.

C. **Retrospective Reviews.**
If the Claims Reviewer has all information necessary to make a determination regarding a retrospective claim, it will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If the Claims Reviewer needs additional information, it will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. The Claims Reviewer will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of receipt of all or part of the requested information or the end of the 45-day period.

Once the Claims Reviewer has all the information to make a decision, its failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

- **Retrospective Review of Preauthorized Services.**
The Claims Reviewer may only reverse a preauthorized treatment, service or procedure on retrospective review when:

(1) The relevant medical information presented to the Claims Reviewer upon retrospective review is materially different from the information presented during the Preauthorization review;
(2) The relevant medical information presented to the Claims Reviewer upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to the Claims Reviewer;
(3) The Claims Reviewer was not aware of the existence of such information at the time of the Preauthorization review; and
(4) Had the Claims Reviewer been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

D. **Step Therapy Override Determinations.**
You, Your designee, or Your Health Care Professional may request a step therapy protocol override determination for Coverage of a Prescription Drug selected by Your

Health Care Professional. When conducting Utilization Review for a step therapy protocol override determination, the Claims Reviewer will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for You and Your medical condition.

- **Supporting Rationale and Documentation.** A step therapy protocol override determination request must include supporting rationale and documentation from a Health Care Professional, demonstrating that:

  (1) The required Prescription Drug(s) is contraindicated or will likely cause an adverse reaction or physical or mental harm to You;
  (2) The required Prescription Drug(s) is expected to be ineffective based on Your known clinical history, condition, and Prescription Drug regimen;
  (3) You have tried the required Prescription Drug(s) while covered by the Plan or under Your previous health insurance coverage, or another Prescription Drug in the same pharmacologic class or with the same mechanism of action, and that Prescription Drug(s) was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
  (4) You are stable on a Prescription Drug(s) selected by Your Health Care Professional for Your medical condition, provided this does not prevent the Plan from requiring You to try an AB-rated generic equivalent; or
  (5) The required Prescription Drug(s) is not in Your best interest because it will likely cause a significant barrier to Your adherence to or compliance with Your plan of care, will likely worsen a comorbid condition, or will likely decrease Your ability to achieve or maintain reasonable functional ability in performing daily activities.

- **Standard Review.** The Claims Reviewer will make a step therapy protocol override determination and provide notification to You (or Your designee) and where appropriate, Your Health Care Professional, within 72 hours of receipt of the supporting rationale and documentation.

- **Expedited Review.** If You have a medical condition that places Your health in serious jeopardy without the Prescription Drug prescribed by Your Health Care Professional, the Claims Reviewer will make a step therapy protocol override determination and provide notification to You (or Your designee) and Your Health Care Professional within 24 hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request, the Claims Reviewer will request the information within 72 hours for Preauthorization and retrospective reviews, the lesser of 72 hours or one (1) business day for concurrent reviews, and 24 hours for expedited reviews. You or Your Health Care Professional will have 45 calendar days to submit the information for Preauthorization, concurrent and retrospective reviews, and 48 hours for expedited reviews. For Preauthorization reviews, the Claims Reviewer will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For concurrent reviews, the Claims Reviewer will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours or one (1) business day of receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For retrospective reviews, the Claims

Reviewer will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours of receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For expedited reviews, the Claims Reviewer will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 24 hours of receipt of the information or 48 hours of the end of the 48-hour period if the information is not received.

If the Claims Reviewer does not make a determination within 72 hours (or 24 hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved.

If the Claims Reviewer determines that the step therapy protocol should be overridden, the Plan will authorize immediate coverage for the Prescription Drug prescribed by Your treating Health Care Professional. An adverse step therapy override determination is eligible for an Appeal.

E. **Reconsideration.**
If the Claims Reviewer did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

F. **Notice of Adverse Determination**
A notice of adverse determination (notice that a service is not Medically Necessary or is experimental/investigational) will include the reasons, including clinical rationale, for the Claim Reviewer's determination, date of service, provider name, claim amount (if applicable), and indicate that the diagnosis code and treatment code, and corresponding meaning of these codes, are available upon request. The notice will also advise You of Your right to appeal the Claim Reviewer's determination, give instructions for requesting a standard or expedited internal Appeal and initiating an external appeal.

The notice will specify that You may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for the Claims Reviewer to review an Appeal and an explanation of why the information is necessary. The notice will also refer to the Plan provision on which the denial is based. The Claims Reviewer will send notices of determination to You (or Your designee) and to Your health care provider.

G. **Utilization Review Internal Appeals.**
You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. The Claims Reviewer will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform

You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

- **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when the Claims Administrator determines that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:

  (1) A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that the Claims Reviewer approved to treat Your condition; and
  (2) Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

- **Out-of-Network Authorization Denial.** You also have the right to Appeal the denial of a request for an authorization to a Non-Participating Provider when the Claims Administrator determines that there is a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network authorization denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:

  (1) That the Participating Provider recommended by the Claims Administrator does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
  (2) Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

H. **Standard Appeal.**

- **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, the Claims Reviewer will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

- **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, the Claims Reviewer will decide the Appeal within the earlier of 30 calendar days of receipt of the information necessary to conduct the Appeal or 60 days of receipt of the Appeal. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

- **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal. Written notice of the determination will be provided to You (or Your designee) within 24 hours after the determination is made, but no later than 72 hours after receipt of the Appeal request.

  If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external appeal.

  The Claims Reviewer's failure to render a determination of Your Appeal within 30 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

- **Substance Use Appeal.** If the Claims Reviewer denies a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or Your Provider file an expedited internal Appeal of the adverse determination, the Claims Reviewer will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external appeal within 24 hours of receipt of the adverse determination, the Plan will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

I. **Notice of Determination of Internal Appeal.**
The notice of determination of Your internal appeal will indicate that it is a "final adverse determination" and will include the clinical rationale for the Claim Reviewer's decision. It will also explain Your rights to an external appeal, together with a description of the external appeal process and the time frames for initiating an external appeal. The Claim Reviewer will send notices of determination to You or Your designee and to Your health care provider.

J. **Full and Fair Review of an Appeal.**
The Claim Reviewer will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by the Claim Reviewer or any new or additional

rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

K. **Appeal Assistance.**
If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XVIII. EXTERNAL APPEAL

Your Right to an External Appeal.
In some cases, You have a right to an external appeal of a denial of coverage. If the Claims Reviewer has denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment; or is an emergency service or a surprise bill (including whether the correct Cost-Sharing was applied), You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

A. The service, procedure, or treatment must otherwise be a Covered Service under this Booklet; and
B. In general, You must have received a final adverse determination through the internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the internal Appeal process if:

- The Claims Reviewer agreed in writing to waive the internal Appeal. The Claims Reviewer is not required to agree to Your request to waive the internal Appeal; or
- You file an external appeal at the same time as You apply for an expedited internal Appeal; or
- The Claims Reviewer fails to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and the Claims Reviewer demonstrates that the violation was for good cause or due to matters beyond its control and the violation occurred during an ongoing, good faith exchange of information between You and the Claims Reviewer).

Your Right to Appeal a Determination that a Service is Not Medically Necessary.
If the Claims Reviewer has denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal above.

Your Right to Appeal a Determination that a Service is Experimental or Investigational.
If the Claims Reviewer has have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal above and Your attending Physician must certify that Your condition or disease is one for which:

- Standard health services are ineffective or medically inappropriate; or
- There does not exist a more beneficial standard service or procedure Covered by the Plan; or
- There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard

Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or

- A clinical trial for which You are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

Your Right to Appeal a Determination that a Service is Out-of-Network.
If the Claims Reviewer has denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in the external appeal paragraph above, and You have requested Preauthorization for the out-of-network treatment.

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

Your Right to Appeal an Out-of-Network Authorization Denial to a Non-Participating Provider. If the Claims Reviewer has denied coverage of a request for an authorization to a Non-Participating Provider because it determined that there is a Participating Provider available with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in external appeal paragraph above.

In addition, Your attending Physician must: 1) certify that the Participating Provider recommended by the Plan does not have the appropriate training and experience to meet Your particular health care needs; and 2) recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for

the health service.

Your Right to Appeal a Formulary Exception Denial.
If the Claims Reviewer has denied Your request for coverage of a non-formulary Prescription Drug through the formulary exception process, You, Your designee or the prescribing Health Care Professional may appeal the formulary exception denial to an External Appeal Agent. See the Prescription Drug Coverage section of this Booklet for more information on the formulary exception process.

Your Right to Appeal a Claim that Involves Consideration of the Plan's Compliance with Surprise Billing and Cost-Sharing Requirements. Certain services Covered under the Plan are subject to the requirements of the federal No Surprises Act, which was enacted as part of the Consolidated Appropriations Act, 2021. The services subject to those requirements are described in Section II under the Protection from Surprise Bills paragraph, as well as in the Booklet provisions that describe coverage of Emergency and urgent care services and air ambulance services. If Your claim involves consideration of whether the Plan is complying with the requirements of those sections, You may appeal to an External Appeal Agent.

The External Appeal Process.
You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on the Claims Reviewer failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

The Claims Reviewer will provide an external appeal application with the final adverse determination issued through the internal Appeal process or with the Claims Reviewer's written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which the Claims Reviewer based the denial, the External Appeal Agent will share this information with the Claims Reviewer in order for it to exercise its right to reconsider its decision. If Claims Reviewer chooses to exercise this right, it will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited external appeal (described below), the Claims Reviewer does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or the Claims Reviewer . If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies

that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and the Claims Reviewer by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If Your internal formulary exception request received a standard review through the Claims Reviewer's formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 72 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within two (2) business days of making a determination. If the External Appeal Agent overturns the Claims Reviewer's denial, the Plan will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

If Your internal formulary exception request received an expedited review through the formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 24 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within 72 hours of receipt of Your completed application. If the External Appeal Agent overturns the Claims Reviewer's denial, the Plan will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-formulary Prescription Drug.

If the External Appeal Agent overturns the Claims Reviewer's decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, the Plan will provide coverage subject to the other terms and conditions of this Booklet. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only Cover the cost of services required to provide treatment to You according to the design of the trial. The Plan will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Booklet for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and the Plan. The External Appeal Agent's decision is admissible in any court proceeding.

The Claims Reviewer will charge You a fee of $25 for each external appeal, not to exceed $75 in a single Plan Year. The external appeal application will explain how to submit the fee. The Claims Reviewer will waive the fee if it determines that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

Your Responsibilities.
It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of

Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or the Claims Reviewer's failure to adhere to claim processing requirements. The Plan has no authority to extend this deadline.

SECTION XIX. Coordination of Benefits

This section applies when You also have group health coverage with another plan. When You receive a Covered Service, the Plan will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

Definitions.

A. "Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

B. "Plan" is other group health coverage with which the benefits under the Plan described in this Booklet will coordinate benefits. The term "plan" includes:

- Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
- Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
- Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private insurance coverage.

C. "Primary plan" is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

D. "Secondary plan" is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

Rules to Determine Order of Payment.

The first of the rules listed below in paragraphs A-F that applies will determine which plan will be primary:

A. If the other plan does not have a provision similar to this one, then the other plan will be primary.

B. If You are covered under the Plan as a Plan Participant and You are only covered as a dependent under the other plan, this Plan will be primary.

C. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year will be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

D. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:

- The plan of the parent who has custody will be primary;
- If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
- If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

E. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

F. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination.
When this Plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this Plan during a claim determination period will not exceed the maximum available benefit for each Covered Service. Also, the amount the Plan pays will not be more than the amount it would pay if the Plan were primary. As each claim is submitted, the Plan will determine its obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Necessary Information.
The Claims Reviewer may release or receive information that it needs to coordinate benefits. The Claims Reviewer does not need to tell anyone or receive consent to do this. The Claims Reviewer is not responsible to anyone for releasing or obtaining this information. You must give the Claims Reviewer any needed information for coordination purposes, in the time frame requested.

The Plan's Right to Recover Overpayment.
If the Plan made a payment as a primary plan, You agree to pay the Plan any amount by which the Plan should have reduced its payment. The Plan has the right to recover any

overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help the Plan recover any overpayment.

Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans. Except as described below, the Plan will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

A. If this Plan is primary, as defined in this section, this Plan will pay benefits first.

B. If this Plan is secondary, as defined in this section, this Plan will pay only the amount this Plan would pay as the secondary insurer.

C. If Claims Reviewer requests information from a non-complying plan and do not receive it within 30 days, the Plan will calculate the amount the Plan should pay on the assumption that the non-complying plan and this Plan provide identical benefits. When the information is received, the Plan will make any necessary adjustments.

SECTION XX. Termination of Coverage

Coverage under this Plan will automatically be terminated on the first of the following to apply:

A. If You failed to pay premiums within 30 days of when the premium equivalent is due, coverage will terminate as of the last day for which premium equivalent payments were paid.

B. The end of the month in which the Plan Participant ceases to meet the eligibility requirements, of the Participating Employer in which such participant is employed, for coverage under the Plan.

C. Upon the Plan Participant's death, coverage will terminate unless the Plan Participant has coverage for Dependents. If the Plan Participant has coverage for Dependents, then coverage will terminate as of the last day of the month for which the premium equivalent has been paid.

D. For Spouses in cases of divorce, the date of the divorce. For Domestic Partners in cases of termination of a domestic partnership, the date of termination.

E. For Dependent Children, the end of the month in which the Dependent Child turns 26 years of age or otherwise no longer satisfies the eligibility requirements for Dependent Child coverage under the Plan.

F. For all other Dependents, the end of the month in which the Dependent ceases to be eligible.

G. The end of the month following the date the Plan Participant provides written notice, to the Participating Employer they are employed, requesting termination of coverage under the Plan, or on such later date requested for such termination by the notice.

H. If the Plan Participant or the Plan Participant's Dependent (or someone acting on behalf of the Plan Participant or Dependent) has performed an act that constitutes fraud or the Plan Participant (or someone acting on behalf of the Plan Participant) has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by the Plan to the Plan Participant or the Dependent, as applicable. However, if the Plan Participant makes an intentional misrepresentation of material fact in writing on his or her enrollment application, the Plan will rescind coverage if the facts misrepresented would have led the Plan to refuse to provide the coverage under the Plan. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment date under the Plan. If termination is a result of the Plan Participant's action, coverage will terminate for the Plan Participant and any covered Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

I. If the Plan elects to terminate or to stop offering all hospital, surgical and medical expense coverage, the Plan will provide written notice to Plan Participant's at least 180 days prior to when the coverage will cease.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the Continuation of Coverage section of this Booklet for Your right to continuation of this coverage. See the Conversion Right to a New Contract after Termination section of this Booklet for Your right to conversion to an individual Contract.

SECTION XXI. Extension of Benefits

When Your coverage under this Booklet ends, benefits stop. But, if You are totally disabled (as determined by the Claims Reviewer) on the date Your coverage under this Booklet terminates, continued benefits may be available for the treatment of the injury or sickness that is the cause of the total disability.

When You May Continue Benefits.
When Your coverage under this Booklet ends, the Plan will provide benefits during a period of total disability for a Hospital stay commencing, or surgery performed, within 31 days from the date Your coverage ends. The Hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability.

If Your coverage ends because You are no longer employed, the Plan will provide benefits during a period of total disability for up to 12 months from the date Your coverage ends for Covered Services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.

Termination of Extension of Benefits.
Extended benefits will end on the earliest of the following:

- The date You are no longer totally disabled;
- The date the contractual benefit has been exhausted;
- 12 months from the date extended benefits began (if Your benefits are extended based on termination of employment); or
- With respect to the 12-month extension of coverage, the date You become eligible for benefits under any group policy providing medical benefits.

Limits on Extended Benefits.
The Plan will not pay extended benefits:

- For any Member who is not totally disabled on the date coverage under this Booklet ends; or
- Beyond the extent to which the Plan would have paid benefits under this Booklet if coverage had not ended.

SECTION XXII. Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. If You are not entitled to temporary continuation of coverage under COBRA, You may be entitled to temporary continuation coverage under the New York Insurance Law as described below. Call or write the Participating Employer by which You are employed to find out if You are entitled to temporary continuation of coverage under COBRA or under the New York Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York Insurance Law.

Note: This provision is extended to coverage of Domestic Partners and to Children of a Domestic Partner.

Qualifying Events.
Pursuant to federal COBRA and state continuation coverage laws, You, the Plan Participant, Your Spouse and Your Children may be able to temporarily continue coverage under the Plan in certain situations when You would otherwise lose coverage, known as qualifying events.

A. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g., a reduction in the number of hours of employment), You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.

B. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
- Voluntary or involuntary termination of the Plan Participant's employment;
- Reduction in the hours worked by the Plan Participant or other change in the Plan Participant's class;
- Divorce or legal separation from the Plan Participant; or
- Death of the Plan Participant.

C. If You are a covered Child, You may continue coverage if Your coverage ends due to:
- Voluntary or involuntary termination of the Plan Participant's employment;
- Reduction in the hours worked by the Plan Participant or other change in the Plan Participant's class;
- Loss of covered Child status under the Plan rules; or
- Death of the Plan Participant.

If You want to continue coverage, You must request continuation from Your Participating Employer in writing and make the first premium payment within the 60-day period following the later of:

A. The date coverage would otherwise terminate; or
B. The date You are sent notice by first class mail of the right of continuation by the Plan.

The Plan may charge up to 102% of the combined cost of Your and Your Participating Employer's share of continued coverage.

Continued coverage under this section will terminate at the earliest of the following:

A. The date 36 months after the Plan Participant's coverage would have terminated because of termination of employment;

B. If You are a covered Spouse or Child, the date 36 months after coverage would have terminated due to the death of the Plan Participant, divorce or legal separation, the Plan Participant's eligibility for Medicare, or the failure to qualify under the definition of "Children";

C. The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;

D. The date You become entitled to Medicare;

E. The date to which premium equivalents are paid if You fail to make a timely payment; or

F. The date the Plan terminates. However, if the Plan is replaced with similar coverage, You have the right to become covered under the new Plan for the balance of the period remaining for Your continued coverage.

Coverage Available following Termination of federal COBRA Coverage. Subject to the continuation provisions in this Booklet, and after You have exhausted Your federal continuation benefits, You may continue coverage under the New York continuation of coverage law for: an additional 18 months when You are entitled to 18 months of federal COBRA coverage; and an additional seven months when You are entitled to 29 months of federal COBRA coverage.

Supplementary Continuation, Conversion, and Temporary Suspension Rights During Active Duty.
If You, the Plan Participant are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if the Plan does not voluntarily maintain Your coverage and if:

A. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and

B. You serve no more than four (4) years of active duty.

When the Plan does not voluntarily maintain Your coverage during active duty, coverage under this Booklet will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay required premium equivalent but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

A. Your coverage under the Plan may be resumed as long as You are reemployed or restored to participation in the Plan upon return to civilian status. The right of resumption extends to coverage for Your covered Dependents. For coverage that was suspended while on active duty, coverage under the Plan will be retroactive to the date on which active duty terminated.

B. If You are not reemployed or restored to participation in the Plan upon return to civilian status, You will be eligible for continuation and conversion as long as You apply to the Plan for coverage within 31 days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one (1) year.

Availability of Age 29 Dependent Coverage Extension - Young Adult Option.
Young adults that no longer qualify as Dependents under the terms of the Plan will be eligible to independently purchase extended coverage under the Plan through the age of 29, subject to the following conditions:

A. **Eligibility.** The young adult is eligible to continue coverage under this provision when the young adult:

- Is under the age of 30;
- Is not married and meets the definition of a Child under the terms of the Plan;
- Is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured;
- Lives, works or resides in New York State or the Service Area; and
- Is not covered by Medicare.

The young adult may purchase continuation coverage even if he or she is not financially dependent on his or her parent(s) or does not live with his or her parent(s). In addition, a young adult's eligibility for coverage under federal COBRA or state continuation of coverage laws will not disqualify the young adult for extended coverage under this section.

B. **Election and Effective Date.** The young adult (or Member-parent) that wishes to continue the young adult's coverage must make an election to continue coverage in writing:

- Within 60 days of the date that his or her coverage would otherwise end due to reaching the maximum age for Dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated;

- Within 60 days of newly meeting the eligibility requirements for young adults described under paragraph "A" above, in which case coverage will be prospective and effective within 30 days after the election is made and the first premium equivalent payment is made; or

- During an open enrollment period for coverage described in this Booklet, in which case coverage will be prospective and within 30 days after the election is made and

the first premium equivalent payment is made .

C. **Premium Equivalent Payment.** The first premium equivalent payment must accompany the written election in order for continued coverage to take effect. Thereafter, the young adult (or Member-parent) electing coverage must pay the full amount of the required premium equivalent payment on or before the due date of each payment. Any premium equivalent payment received within 30 days after the due date will be considered timely.

D. **Type of Coverage.** The continued coverage will be identical to the coverage that is provided to the Member-parent. If the parent's coverage is modified, the young adult's continued coverage will be likewise modified.

E. **Termination of Coverage.** The continued coverage will end on the earliest of the following:
- The date the young adult voluntarily terminates coverage under the Plan pursuant to its terms;
- The date the young adult's parent is no longer covered under the Plan, including coverage provided under federal COBRA or state continuation of coverage laws;
- The date the young adult becomes 30 years of age;
- The date the young adult no longer meets the eligibility requirements set forth in paragraph "A" above;
- The date to which the last premium equivalent was paid if there is a failure to make the required premium equivalent payment before the end of the 30-day grace period; or
- The date on which the Plan is terminated and not replaced.

F. **Effect of Termination of Continued Coverage.** When a young adult's continued coverage terminates, the young adult will not have an independent right to continue coverage under federal COBRA or state continuation of coverage laws.

SECTION XXIII. General Provisions

Agreements Between the Claims Administrator and Participating Providers.
Any agreement between the Claims Administrator and Participating Providers may only be terminated by the Claims Administrator or the Providers. This Booklet does not require any Provider to accept a Member as a patient. The Claims Administrator does not guarantee a Member's admission to any Participating Provider or any health benefits program.

Assignment.
You cannot assign any benefits or monies due under the Plan to any person, corporation or other organization unless it is an assignment to Your Provider for a surprise bill or to a Hospital for Emergency Services, including inpatient services following Emergency Department Care. Any assignment by You other than for monies due for a surprise bill or an assignment of monies due to a Hospital for Emergency Services, including inpatient services following Emergency Department Care, will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under the Plan or Your right to collect money from the Plan for those services. Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise permitted by applicable law.

Certification of Compliance with Privacy Regulations: A Federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of Your private health information that is maintained or received by the Plan. Such information is referred to as Protected Health Information (PHI) in this section. A complete description of Your privacy rights under HIPAA can be found in the Notice of Privacy Practices (Privacy Notice) You received when You enrolled. A copy of the Privacy Notice is available upon request from the GTCMHIC or Your Participating Employer.

Under HIPAA You have certain rights with respect to Your PHI, including but not limited to, the right to see and copy the information, receive an accounting of certain disclosures of the information and to amend the PHI under certain circumstances.

The Plan may disclose PHI to a Participating Employer or allow the Claims Administrator or the Prescription Drug Benefit Manager (as applicable) to make a disclosure to the Participating Employer as follows:

A. **Summary Health Information.** The Plan (or the Claims Administrator or the Prescription Drug Benefit Manager (as applicable) on behalf of the Plan) may disclose PHI that is summary health information to the Participating Employer, if the Participating Employer requests the summary health information for the purpose of obtaining premium bids from insurance issuers for providing health insurance coverage under the Plan or amending the Plan. "Summary health information" is Plan information that summarizes claims information for the Plan from which most individual identifying information has been removed.

B. **Enrollment Information.** The Plan(or the Claims Administrator or the Prescription Drug Benefit Manager (as applicable) on behalf of the Plan) may disclose to the Participating Employer information on whether an individual is participating in the Plan.

C. **Other Disclosures to a Participating Employer.** Except as provided above or under the terms of an applicable individual authorization, the Plan (or the Claims

Administrator or the Prescription Drug Benefit Manager (as applicable) on behalf of the Plan) may disclose PHI to the Participating Employer, provided that the Participating Employer agrees to the following, which the Participating Employer has done by executing the Greater Tompkins Municipal Cooperative Health Benefit Plan Municipal Corporation Agreement:

(1) the Participating Employer will not use or further disclose PHI other than as permitted by the Plan or as required by law;

(2) the Participating Employer will ensure that any agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Participating Employer with respect to such information;

(3) the Participating Employer will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Participating Employer;

(4) the Participating Employer will report to the Plan any use or disclosure, of which it becomes aware, of PHI that is inconsistent with the uses or disclosures permitted under the Plan;

(5) the Participating Employer will make PHI available to the individual who is the subject of that information in accordance with the Privacy Regulations;

(6) the Participating Employer will consider requested amendments to an individual's PHI in accordance with the Privacy Regulations;

(7) the Participating Employer will make available the information required to provide an accounting of disclosures of PHI in accordance with the Privacy Regulations;

(8) the Participating Employer will make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Regulations;

(9) the Participating Employer will, if feasible, return or destroy all PHI received from the Plan that the Participating Employer still maintains in any form and will retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if return or destruction is not feasible, the Participating Employer will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(10) the Participating Employer will ensure that the adequate separation of the Plan and the Participating Employer as required in this section is established.

D. **Prohibited Disclosures.** The Plan will not disclose PHI to the Participating Employer for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Participating Employer.

E. **Separation of Health Plan and the Participating Employer.** The Participating Employer has designated and trained certain employees to be the only employees of

the Participating Employer who will have access to PHI. Only those trained and authorized employees will use or disclose PHI on behalf of the Plan and only to the extent appropriate for performing administrative services that the Participating Employer provides for the Plan.

The Participating Employer will work with the Plan's designated Privacy Official to establish effective policies and procedures for identifying, investigating, remedying and disciplining any alleged instances of noncompliance with the requirement that employees of the Participating Employer who have access to PHI use that PHI only for the purposes specified in this section.

F. **Privacy Notice.** The Plan will comply with the applicable requirements of the Plan's Privacy Notice, which is incorporated into the Plan by this reference. If the Privacy Notice is revised, the Plan will comply with the revised Privacy Notice as of the effective date of the revision. A revised Privacy Notice is incorporated into the Plan as of the effective date of each revision without the need for further amendment of the Plan. You may request a copy of the Notice of Privacy Practices from the Participating Employer or the Privacy Officer.

G. **Security Regulations**. The Plan (or the Claims Administrator or the Prescription Drug Benefit Manager (as applicable) on behalf of the Plan) will comply with all applicable requirements of the HIPAA Security Regulations.

In addition, the Participating Employer agrees that it will:

(1) Reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Participating Employer on behalf of the Plan;

(2) Implement and maintain administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(3) Ensure that the adequate separation of the Participating Employer and the Plan required by the Privacy Regulations is supported by reasonable and appropriate security measures;

(4) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect that information; and

(5) Report to the Plan any security incident of which it becomes aware.

H. **Breach Reporting.** The Participating Employer will promptly report to the Plan any breach of unsecured PHI of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HIPAA Security Breach Regulations.

Choice of Law.
This Booklet shall be governed by the laws of the State of New York.

Clerical Error.
Clerical error, whether by the GTCMHIC, Participating Employer, Claims Administrator or Prescription Drug Benefit Manager, with respect to this Booklet, or any other documentation issued in connection with this Booklet, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Continuation of Benefit Limitations.
Some of the benefits in this Booklet may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change mid-Plan Year. For example, if Your coverage status changes from Dependent to Plan Participant, all benefits previously utilized when You were a Dependent will be applied toward Your new status as a Plan Participant.

Enrollment.
The Participating Employers will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages, and social security numbers of all Members covered under this Booklet, and any other information required to confirm their eligibility for coverage. The Plan will provide the Claims Administrator and Prescription Drug Benefit Manager with Your enrollment information, including Your name, address, age, and social security number and advise the Claims Administrator and Prescription Drug Benefit Manager in writing when You are to be added to or subtracted from the list of Members, on a monthly basis.

Fraud and Abusive Billing.
The Plan has processes in place to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

Furnishing Information and Audit.
all persons covered under this Booklet will promptly furnish the Claims Administrator and/or Prescription Drug Benefit Manager with all information and records that it may require from time to time to perform its obligations under this Booklet. You must provide the Claims Administrator and/or Prescription Drug Benefit Manager with information over the telephone for reasons such as the following: to determine the level of care You need; so that the Claims Review may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care.

Identification Cards.
Identification ("ID") cards are issued by the Claims Administrator for identification purposes only. Possession of any ID card confers no right to services or benefits under this Booklet. To be entitled to such services or benefits, the Member's premium equivalents must be paid in full at the time the services are sought to be received.

Incontestability.
No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be

deemed representations and not warranties.

Independent Contractors.
Participating Providers are independent contractors. They are not agents or employees of the Plan or the Claims Administrator. The Claims Administrator is not the agent or employee of any Participating Provider. The Plan or Claims Administrator are are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your covered Spouse or Children while receiving care from any Participating Provider or in any Participating Provider's Facility.

Inter-Plan Arrangements Disclosure - Out-of-Area Services. The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever You obtain healthcare services outside of the Claims Administrator's Service Area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program.

Typically, when accessing care outside the Service Area, You will obtain care from healthcare providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, You may obtain care from Non-Participating Providers. The Claims Administrator's payment practices in both instances are described below.

(1) **BlueCard® Program.** Under the BlueCard® Program, when You access Covered health care services within the geographic area served by a Host Blue, the Claims Administrator will remain responsible to Employer for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its In-Network Providers.
Whenever You access Covered health care services outside the Claims Administrator's Service Area and the claim is processed through the BlueCard Program, the amount You pay for Covered health care services is calculated based on the lower of:

(2) The provider's billed Covered charges for Your Covered Services; or

(3) The negotiated price that the Host Blue makes available to the Claims Administrator. This negotiated price will be one of the following:

(a) Often, a simple discount that reflects an actual price that the Host Blue pays to Your provider;

(b) Sometimes, an estimated price that takes into account special arrangements with Your provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges; or

(c) Occasionally, an average price, based on a discount that results in expected average savings for similar types of providers after taking into account the same types of transactions as with an estimated price.
Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Claims Administrator uses for Your

claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to Your calculation. If any state laws mandate other liability calculation methods, including a surcharge, the Claims Administrator would then calculate Your liability for any Covered health care services according to applicable law.

(4) **Calculation of Member Liability for Services of Non-Participating Providers outside the Claims Administrator's Service Area.** The Allowed Amount definition in this Plan, as amended from time-to-time, describes how the Claims Administrator's payment (the "Allowed Amount") for Covered Services of Non-Participating Providers outside its Service Area is calculated. The Allowed Amount may be based upon the amount provided to the Claims Administrator by the Host Blue or the payment it would make to Non-Participating Providers inside its Service Area. Regardless of how the Allowed Amount is calculated, You will be liable for the amount, if any, by which the provider's actual charge exceeds the Allowed Amount, which amount is in addition to any other Cost-Sharing (Deductible, Copayment or Coinsurance) required by this Plan.

More Information about Your Plan.
You can request additional information about Your coverage under this Booklet by contacting the GTCMHIC, Your Participating Employer, the Claims Administrator or Prescription Drug Benefit Manager. Examples of information You may request are as follows:

- A copy of the drug formulary. You may also inquire if a specific drug is Covered under this Booklet.
- A copy of the medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with participating Hospitals.
- A copy of the clinical review criteria(e.g., Medical Necessity criteria), and where appropriate, other clinical information the Plan may consider regarding a specific disease, course of treatment or Utilization Review guidelines, including clinical review criteria relating to a step therapy protocol override determination.
- Written application procedures and minimum qualification requirements for Providers.
- Documents that contain the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the Plan.

Notice.
Any notice given to You under this Booklet will be mailed to Your address as it appears on the Claims Administrator or Prescription Drug Benefit Manager's records or delivered electronically if You consent to electronic delivery. If notice is delivered to You electronically, You may also request a copy of the notice from the Plan or the Claims Administrator or Prescription Drug Benefit Manager (as applicable). You agree to provide the Claims Administrator or Prescription Drug Benefit Manager (as applicable) with notice of any change of Your address. If You have to give the Claims Administrator or Prescription Drug Benefit Manager (as applicable) any notice, it should be sent by U.S. mail, first class, postage prepaid to the address of the Claims Administrator at 165 Court Street, Rochester, NY 14647 or the Prescription Drug Benefit Manager at the address identified in the Definitions section of this Booklet.

Recovery of Overpayments.
On occasion, a payment may be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens, the Plan will explain the problem to You and You must return the amount of the overpayment to the Plan within 60 days after receiving notification from the Plan. However, the Plan shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless it have a reasonable belief of fraud or other intentional misconduct.

Right to Develop Guidelines and Administrative Rules.
The Claims Administrator and/or Prescription Drug Benefit Manager (as applicable) may develop or adopt standards that describe in more detail when the Plan will or will not make payments under this Booklet. Examples of the use of the standards are: to determine whether: Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat Your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Booklet. If You have a question about the standards that apply to a particular benefit, You may contact the Claims Administrator and/or Prescription Drug Benefit Manager (as applicable) and they will explain the standards or send You a copy of the standards. The Claims Administrator and/or Prescription Drug Benefit Manager (as applicable) may also develop administrative rules pertaining to enrollment and other administrative matters. The GTCMHIC shall have all the powers necessary or appropriate to enable it to carry out its duties with the administration of the Plan, and may delicate such duties. The GTCMHIC has delegated claim processing authority to the Claims Administrator and Prescription Drug Benefit Manager (as applicable).

The Claims Administrator and Prescription Drug Benefit Manager (as applicable) review and evaluate new technology according to technology evaluation criteria developed by its medical directors and reviewed by a designated committee, which consists of Health Care Professionals from various medical specialties. Conclusions of the committee are incorporated into medical policies to establish decision protocols for determining whether a service is Medically Necessary, experimental or investigational, or included as a Covered benefit.

Right to Offset.
If the Plan makes a claim payment to You or on Your behalf in error or You owe the Plan any money, You must repay the amount You owe the Plan. Except as otherwise required by law, if the Plan owes You a payment for other claims received, the Plan has the right to subtract any amount You owe it from any payment the Plan owes You.

Service Marks.
Excellus Health Plan, Inc. (“Excellus”) is an independent corporation organized under the New York Insurance Law. Excellus also operates under licenses with the Blue Cross Blue Shield Association, an association of independent Blue Cross Blue Shield Plans, which licenses Excellus to use the Blue Cross and Blue Shield service marks in a portion of New York State. Excellus does not act as an agent of the Blue Cross Blue Shield Association. Excellus is solely responsible for the obligations created under the Administrative Service Contract between the GTCMHIC and Excellus.

Services will not be Denied Based on Gender Identity. The Plan will not limit coverage or impose additional cost sharing for any otherwise-Covered Services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the gender for which such health services are ordinarily available. In such cases, the Plan generally will rely on recommendations of the treating physician, the Claims Administrator or Prescription Drug Benefit Manager (as applicable) medical policies, and applicable legal guidance to determine if a particular service is Medically Necessary.

Severability.
The unenforceability or invalidity of any provision of this Booklet shall not affect the validity and enforceability of the remainder of this Booklet.

Subrogation and Reimbursement.
These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your injury, illness or other condition and the Plan has provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, the Plan may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits the Plan has provided to You under this Booklet. Subrogation means that the Plan has a right, independently of You, to proceed directly against the other party to recover the benefits that the Plan has provided.

Subject to applicable state law, unless preempted by federal law, the Plan may have a right of reimbursement if You or anyone on Your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for the Plan provided benefits. Under New York General Obligations Law Section 5-335, the Plan's right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against the Plan's rights or violate any contract between You and the Plan. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which the Plan provided benefits.

The Plan requests that You notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which the Plan has provided benefits. You must provide all information requested by the Plan or its representatives including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request.

You agree to cooperate with the Plan's reimbursement and subrogation rights as the Plan may request and You agree not to prejudice the Plan's rights under this provision in any manner.

Time to Sue.
No action at law or in equity may be maintained against the Plan prior to the expiration of 60 days after written submission of a claim has been furnished to the Plan as required in this Booklet. You must start any lawsuit against the Plan under this Booklet within two (2) years from the date the claim was required to be filed.

Translation Services.
Translation services are available free of charge under this Booklet for non-English speaking Members. Please contact the Claims Administrator at the number on Your ID card or the Prescription Drug Benefit Manager at 877-635-9545 to access these services.

Venue for Legal Action.
If a dispute arises under this Booklet, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against the Plan in a court anywhere else. You also consent to New York State courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action the Plan may bring against You.

Who May Change this Booklet.
This Booklet may not be modified, amended, or changed, except in writing and signed by the GTCMHIC or a person designated by the GTCMHIC. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Booklet in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the GTCMHIC or person designated by the GTCMHIC.

Who Receives Payment under this Booklet.
Payments under the Plan for services rendered by a Participating Provider will be made directly to the Provider. If You receive services from a Non-Participating Provider, the Plan reserves the right to pay either the Plan Participant or the Provider. However, the Plan will directly pay a Provider instead of You for Emergency Services, including inpatient services following Emergency Department Care, pre-hospital emergency medical services, air ambulance services, and surprise bills.

Your Medical Records and Reports.
The Claims Administrator and Prescription Drug Benefit Manager is entitled to receive from any Provider of services to Members, information reasonably necessary to administer the Plan subject to all applicable confidentiality requirements as defined in the General Provisions section of this Booklet. By accepting coverage under this Booklet, the Member, for himself or herself, and for all covered Dependents hereunder, authorizes each and every Provider who renders services to a Member hereunder to:

- Disclose all facts pertaining to the care, treatment and physical condition of the Member to the Claims Administrator or Prescription Drug Benefit Manager (as applicable) or a medical, dental, or mental health professional that the Claims Administrator or Prescription Drug Benefit Manager (as applicable) may engage to assist it in reviewing a treatment or claim, or in connection with a complaint or quality of care review;

- Render reports pertaining to the care, treatment and physical condition of the Member to the Claims Administrator and/or Prescription Drug Benefit Manager, or a medical, dental, or mental health professional, that it may engage to assist it in reviewing a treatment or claim; and

- Permit copying of the Member's records by the Claims Administrator and/or Prescription Drug Benefit Manager (as applicable).

The Plan, the Claims Administrator and/or the Prescription Drug Benefit Manager (as applicable) acting on behalf of the Plan, agrees to maintain that information in accordance with state and federal confidentiality requirements. However, You automatically give the Plan, the Claims Administrator and/or the Prescription Drug Benefit Manager (as applicable), acting on behalf of the Plan, permission to share that information with the New York State Department of Health, quality oversight organizations and third parties with which the Plan contracts to assist it in administering the Plan, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

BLUE COMPREHENSIVE – MEDICAL SCHEDULE OF BENEFITS

	PARTICIPATING PROVIDER You Pay	NON-PARTICIPATING PROVIDER You Pay
PLAN YEAR DEDUCTIBLE (Does not apply to Prescription Drugs)		
Individual	$500	$500
Family	$1,500	$1,500
If You have family coverage, each person within a family must satisfy the individual Deductible listed above before any expenses, subject to the Deductible (as stated in the Schedule of Benefits), will be Covered by the Plan for that person in the Plan Year; however, any combination of family members may satisfy the family Deductible.		
If You use a combination of Participating Providers and Non-Participating Providers, Your total Deductible amount required to be paid will never exceed the Deductible amount shown above for Non-Participating Providers. This means that the Deductible amount You pay for Participating Providers and Non-Participating Providers is combined. Any amounts you pay towards satisfaction of the Participating Provider Deductible will count towards satisfaction of the Non-Participating Provider Deductible and any amounts you pay towards satisfaction of the Non-Participating Provider Deductible will also count towards satisfaction of the Participating Provider Deductible.		
Amounts that accumulate towards Your Deductible for Covered Services during the last three (3) months in a Plan Year and applied to the Deductible for that Plan Year will also be counted toward Your Deductible for the following Plan Year.		
BENEFIT SPECIFIC DEDUCTIBLE – HOME CARE & HOME INFUSION THERAPY		
Individual	$50	$50
The amounts paid towards the benefit specific Deductible will apply towards the Plan Year Deductible; however, the amounts paid towards the Plan Year Deductible will not apply towards the benefit specific Deductible.		
PLAN YEAR OUT-OF-POCKET LIMIT - MEDICAL ONLY		
Individual	$2,500	$2,500
Family	$7,500	$7,500
If You have family coverage, when persons in the same family covered under this Plan option have met the individual Out-of-Pocket Limit (described above) in payment of Cost-Sharing for a Plan Year, the Plan will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person. The Out-of-Pocket Limit for services rendered by a Participating Provider is combined with the Out-of-Pocket Limit for services rendered by a Non-Participating Provider.		

BLUE COMPREHENSIVE - MEDICAL BENEFITS		
	PARTICIPATING PROVIDER (Subject to the Allowed Amount) **You Pay**	**NON-PARTICIPATING PROVIDER** (Subject to the Allowed Amount) **You Pay**
Advanced Imaging Services (Outpatient) (MRI,PET scans, CAT scans, and nuclear medicine)		
Facility services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Professional services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Allergy Services		
Testing	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Treatment (including serum)	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Ambulance Services		
Pre-hospital emergency services (ground ambulance	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Air ambulance	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Water ambulance	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Inter Hospital transportation	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Ambulatory Surgical Center		
Facility services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Professional services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Anesthesia Services (all settings)	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Biofeedback	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Cardiac and Pulmonary Rehabilitation (Outpatient)		
Facility services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Professional services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Chemotherapy (Outpatient)		
Facility services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Professional services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Chiropractic Care	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible

BLUE COMPREHENSIVE - MEDICAL BENEFITS		
	PARTICIPATING PROVIDER (Subject to the Allowed Amount) **You Pay**	**NON-PARTICIPATING PROVIDER** (Subject to the Allowed Amount) **You Pay**
Cochlear Implants	See Internal Prosthetic Devices Cost-Sharing	See Internal Prosthetic Devices Cost-Sharing
Colonoscopies (Diagnostic)		
Facility services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Professional services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Dialysis (Outpatient)		
Facility services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Professional services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Durable Medical Equipment (DME)	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Emergency Department		
Facility services	20% Coinsurance, after Deductible*	20% Coinsurance, after Deductible*
Professional services	20% Coinsurance, after Deductible*	20% Coinsurance, after Deductible*
	**Note: The Cost-Sharing is waived for health care forensic examinations performed under New York Public Health Law §2805-i*	
Foot Orthotics	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Hearing Evaluations		
Diagnostic	20% Coinsurance, after Deductible*	20% Coinsurance, after Deductible*
Home Health Care	20% Coinsurance, after $50 Deductible	20% Coinsurance, after $50 Deductible
Home Infusion Therapy	20% Coinsurance, after $50 Deductible	20% Coinsurance, after $50 Deductible
Hospice Care		
Inpatient	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Outpatient	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Bereavement Counseling	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Plan Year maximum	Bereavement counseling is limited to five (5) visits (Participating Providers and Non-Participating Providers combined)	

BLUE COMPREHENSIVE - MEDICAL BENEFITS		
	PARTICIPATING PROVIDER (Subject to the Allowed Amount) **You Pay**	**NON-PARTICIPATING PROVIDER** (Subject to the Allowed Amount) **You Pay**
Infertility Services (Outpatient)		
Facility services	The same Cost-Sharing that applies to the same or similar Covered Service	The same Cost-Sharing that applies to the same or similar Covered Service
Professional services	The same Cost-Sharing that applies to the same or similar Covered Service	The same Cost-Sharing that applies to the same or similar Covered Service
Lifetime maximum	Limited to three (3) cycles of in vitro fertilization (Participating Providers and Non-Participating Providers combined)	
Infusion Therapy	Included with Your home health care services	Included with Your home health care services
Inpatient Hospital Services		
Facility services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Professional services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the virus that causes COVID-19 Effective as of 03/13/2020 and during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)). The emergency period described above ended on 05/11/2023. Effective as of 05/12/2023.	Plan pays 100% of the Allowed Amount The same Cost-Sharing that applies to the same or similar Covered Service	Plan pays 100% of the Allowed Amount The same Cost-Sharing that applies to the same or similar Covered Service
Lab and Pathology (Outpatient)		
Professional services		
Diagnostic	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Routine	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible

BLUE COMPREHENSIVE - MEDICAL BENEFITS		
	PARTICIPATING PROVIDER (Subject to the Allowed Amount) **You Pay**	**NON-PARTICIPATING PROVIDER** (Subject to the Allowed Amount) **You Pay**
Facility services		
Diagnostic	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Routine	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Mammograms (Diagnostic)		
Facility services	Plan pays 100% of the Allowed Amount	20% Coinsurance, after Deductible
Professional services	Plan pays 100% of the Allowed Amount	20% Coinsurance, after Deductible
Maternity & Newborn Nursery Care (Professional Services)		
Prenatal/post-natal care that is a Preventive Service*	Plan pays 100% of the Allowed Amount	20% Coinsurance, after Deductible
Prenatal/post-natal care that is not a Preventive Service*	The same Cost-Sharing that applies to the same or similar Covered Service	The same Cost-Sharing that applies to the same or similar Covered Service
Delivery (physician or midwife)	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Newborn Nursery Care (Routine)		
Facility services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Professional services	Plan pays 100% of the Allowed Amount	Plan pays 100% of the Allowed Amount
Breastfeeding support, counseling and supplies, including breast pumps	Plan pays 100% of the Allowed Amount	20% Coinsurance, after Deductible
Benefit limitation	Limited to one (1) rental or purchase per pregnancy. (Participating Providers and Non-Participating Providers combined)	
For additional details on what constitutes a Preventive Service, please refer to the Preventive Services subsection of the Preventive Care section of this document.		
Medical Supplies	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Mental Health and Substance Use Disorder Services		
Inpatient services (including residential treatment)	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Outpatient services (including assistive communication devices)	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible

BLUE COMPREHENSIVE - MEDICAL BENEFITS		
	PARTICIPATING PROVIDER (Subject to the Allowed Amount) **You Pay**	**NON-PARTICIPATING PROVIDER** (Subject to the Allowed Amount) **You Pay**
Observation Stays	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Orthotics	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Office Visits		
Primary care or home visits	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Specialist office or home visits	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Physical Rehabilitation (Inpatient)	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Preadmission Testing	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Preventive Care		
Adult annual physical examinations	Plan pays 100% of the Allowed Amount	20% Coinsurance, after Deductible
Plan Year maximum	One (1) examination (Participating Providers and Non-Participating Providers combined)	
Adult immunizations	Plan pays 100% of the Allowed Amount	Not Covered
Bone density testing that is considered a Preventive Service*	Plan pays 100% of the Allowed Amount	20% Coinsurance, after Deductible
Bone density testing that is not considered a Preventive Service*	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Colonoscopies that are considered a Preventive Service	Plan pays 100% of the Allowed Amount	20% Coinsurance, after Deductible
Colonoscopies that are not considered a Preventive Service	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
COVID-19 Vaccine Effective as of 15 business days after a recommendation is made by the U.S. Preventive Services Task Force or CDC Advisory Committee on Immunization Practices	Plan pays 100% of the Allowed Amount	**Prior to 05/12/2023:** Plan pays 100% of the Allowed Amount **On or after 05/12/2023:** Not Covered

BLUE COMPREHENSIVE - MEDICAL BENEFITS		
	PARTICIPATING PROVIDER (Subject to the Allowed Amount) **You Pay**	**NON-PARTICIPATING PROVIDER** (Subject to the Allowed Amount) **You Pay**
Gynecological services/well woman exams	Plan pays 100% of the Allowed Amount	20% Coinsurance, after Deductible
Plan Year maximum	Gynecological services/well woman exams are limited to one (1) exam (Participating Providers and Non-Participating Providers combined)	
Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Plan pays 100% of the Allowed Amount	20% Coinsurance, after Deductible
Elective sterilization		
Female	Plan pays 100% of the Allowed Amount	20% Coinsurance, after Deductible
Male	The applicable Cost-Sharing based on Covered Service provided	The applicable Cost-Sharing based on Covered Service provided
Prostate cancer screenings	Plan pays 100% of the Allowed Amount	20% Coinsurance, after Deductible
Well child visits and immunizations	Plan pays 100% of the Allowed Amount	Plan pays 100% of the Allowed Amount
Preventive care that is considered a Preventive Service and not otherwise listed above*	Plan pays 100% of the Allowed Amount	The same Cost-Sharing that applies to the same or similar Covered Service
Preventive care that is not considered a Preventive Service*	The same Cost-Sharing that applies to the same or similar service	The same Cost-Sharing that applies to the same or similar service
For additional details on what constitutes a Preventive Service, please refer to the Preventive Services subsection of the Preventive Care section of this document.		
Prosthetic Devices		
External	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Implanted	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Mastectomy	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible

BLUE COMPREHENSIVE - MEDICAL BENEFITS		
	PARTICIPATING PROVIDER (Subject to the Allowed Amount) **You Pay**	**NON-PARTICIPATING PROVIDER** (Subject to the Allowed Amount) **You Pay**
PUVA Treatment	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Radiation Therapy (Outpatient)		
Facility services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Professional services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Rehabilitation/Habilitation Services (Occupational therapy, physical therapy, speech therapy)		
Facility services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Professional services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Plan Year maximum	45 visits, all therapy limits combined (Participating Providers and Non-Participating Providers combined)	
Skilled Nursing Facility	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Surgical Procedures		
Inpatient		
Facility services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Professional services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Outpatient		
Facility services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Professional services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Office surgery	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Telehealth*	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
*Note: Coverage for telehealth related to the furnishing or administration of certain tests for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 for services rendered by a Participating Provider or Non-Participating Provider prior to 05/12/2023 is not subject to the Cost-Sharing specified above. Coverage for telehealth in this situation is provided in accordance with the section of this Plan entitled “In Vitro Diagnostic Tests for the Detection of SARS-CoV-2 or the Diagnosis of the virus that causes COVID-19”.		
Telemedicine Program – MD Live	20% Coinsurance, after Deductible	Not Covered

BLUE COMPREHENSIVE - MEDICAL BENEFITS		
	PARTICIPATING PROVIDER (Subject to the Allowed Amount) **You Pay**	**NON-PARTICIPATING PROVIDER** (Subject to the Allowed Amount) **You Pay**
Transplants		
	Preauthorization required for transplant services rendered by a Participating Provider or Non-Participating Provider	
	The same Cost-Sharing that applies to the same or similar service	The same Cost-Sharing that applies to the same or similar service
Treatment of Diabetes		
Diabetic insulin	See the applicable Prescription Drug Schedule of Benefits option for Cost-Sharing	See the applicable Prescription Drug Schedule of Benefits option for Cost-Sharing
Diabetic supplies	20% Coinsurance	20% Coinsurance
Diabetic education	20% Coinsurance	20% Coinsurance
Diabetic equipment	20% Coinsurance	20% Coinsurance
Urgent Care Center		
Facility services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Professional services	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Vision Care		
Diagnostic eye exams	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
X-Rays (Outpatient)		
Facility services		
Diagnostic	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Routine	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Professional services		
Diagnostic	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible
Routine	20% Coinsurance, after Deductible	20% Coinsurance, after Deductible

PLAN OPTION 3T11 - PRESCRIPTION DRUG SCHEDULE OF BENEFITS

	PARTICIPATING PHARMACY (Subject to the Allowed Amount) **You Pay**	**NON-PARTICIPATING PHARMACY** (Subject to the Allowed Amount) **You Pay**
PLAN YEAR DEDUCTIBLE		
Individual	None	Not Covered
Family	None	Not Covered
PLAN YEAR OUT-OF-POCKET LIMIT (This Out-of-Pocket Limit is separate from Your medical Out-of-Pocket Limit)		
Individual	$2,000	Not Covered
Family	$6,000	Not Covered
Retail Pharmacy – 30-day supply		
Generic Drug	20% Coinsurance	Not Covered
Preferred Brand Drug	20% Coinsurance	Not Covered
Non-Preferred Brand Drug	40% Coinsurance	Not Covered
Diabetic Drugs, Equipment & Supplies (to the extent not covered under medical)	20% Coinsurance	Not Covered
Mail Order Pharmacy – 90-day supply		
Generic Drug	15% Coinsurance	Not Covered
Preferred Brand Drug	15% Coinsurance	Not Covered
Non-Preferred Brand Drug	40% Coinsurance	Not Covered
Diabetic Drugs, Equipment & Supplies (to the extent not covered under medical)	20% Coinsurance	Not Covered
Preauthorization Requirement. Certain Prescription Drugs require Preauthorization. If You don't get Preauthorization, Your Prescription Drug will not be Covered. You can view a list of Prescription Drugs that require Preauthorization by visiting www.proactrx.com. You may also request a copy, free of charge by calling the Prescription Drug Benefit Manager at 877-635-9545.		
Step Therapy. Step therapy applies. Refer to the Prescription Drug Coverage section (Section XIII) of this Booklet for additional information regarding the step therapy program.		
Specialty Drugs. Specialty drugs require Preauthorization and must be obtained from the specialty Prescription Drug Designated Pharmacy. Specialty drugs are not eligible for mail order.		
Formulary. The list that identifies those Prescription Drugs for which coverage may be available under this Plan. This list is subject to periodic review and modification. You may determine to which tier a particular Prescription Drug has been assigned by visiting www.proactrx.com or by calling the Prescription Drug Benefit Manager at 877-635-9545.		